

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02494

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 28 HRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES		d. STREET ADDRESS RT. #4		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY L. AARON		First Middle Last		4. DATE OF DEATH MARCH 19 1959		Month Day Year	
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG. 27, 1890	
9. AGE (In years last birthday) 68 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		11. KIND OF BUSINESS OR INDUSTRY At home		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph H. BENJAMIN WELLER		14. MOTHER'S MAIDEN NAME LAURA WERTZ		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-05-7175	
17. INFORMANT MEMORIAL HOSPITAL		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction, Post- partum 2 days DUE TO arteriosclerosis & Hypertension cardio-muscular 3. P. Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Diabetes mellitus DUE TO (b) Diabetes mellitus (c) Diabetes mellitus INTERVAL BETWEEN ONSET AND DEATH 10 years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1 Jan. , 1950, to 19 Mar. , 1959, that I last saw the deceased alive on 19 Mar. , 1959, and that death occurred at 12:40 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE W. Alfred Van Ormer M.D.		ADDRESS (Street, city or town, state) 122 S. Centre St. Cumberland, Md.		DATE SIGNED 21 Mar. 54			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/22/59		22c. NAME OF CEMETERY OR CREMATORIUM RoseHill Cemetery		22d. LOCATION (City, town, or county) Cumberland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox		ADDRESS Cumberland Maryland		24a. REC'D BY REGISTRAR DATE MAR 23 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by me funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF HEALTH - SEATTLE

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02495

CERTIFICATE OF DEATH

Reg. Dist. No.

259

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	c. LENGTH OF STAY IN 1b 37 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	d. STREET ADDRESS 719 MARYLAND AVENUE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First VIRGINIA	Middle Clara	Last AFRICA			
4. DATE OF DEATH MARCH 14 1959	Month	Day	Year			
5. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JANUARY 6, 1906	9. AGE (In years lost birthday) 53 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) MARYLAND, Cumberland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME GEORGE S. EASTON		14. MOTHER'S MAIDEN NAME LULA A. EVERSOLE				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		18. WARWICK & MEMORIAL AVENUE
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.8 DUE TO Carcinoma metastatic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma, Colon spreading to bones (c) and lungs						INTERVAL BETWEEN ONSET AND DEATH 5 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from _____, 1954, to 14 Mar, 1959, that I last saw the deceased alive on 14 Mar, 1959, and that death occurred at 2:25 A.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state) M.D. 232 Autumn Ave. Cumberland, Md.
ACTUAL SIGNATURE Carlton Brinsfield						DATE SIGNED 3-14-59
PHYSICIAN'S NAME (Type) DR. CARLTON BRINSFIELD						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/17/59		22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland			ADDRESS		24a. REC'D BY REGISTRAR MAR 19 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02496

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

M

2570

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN lb 3yrd.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miners Hospital		e. STREET ADDRESS 165 E. Main St.	
3. NAME OF DECEASED (Type or print) Nelson		First Junior	Middle Albright
4. DATE OF DEATH Mar 29	Month Month	Day Day	Year 1959
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 1-2-1934
9. AGE (In years less birthday) 25 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Hours 0	IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY P & K Garage	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Nelson Wm. Albright		14. MOTHER'S MAIDEN NAME Leona Fazenbaker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-28-9967	
		17. INFORMANT Mr. Robert Garlock Rt. #2 Zihlman, Address Frostburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 754.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Part Cerebral Hemorrhage (b) DUE TO Posture of Congenital Anoxia (c) of the Meningeal Artery			
INTERVAL BETWEEN ONSET AND DEATH 3/3 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE W. O. M. Albright		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) W. O. M. Albright		DATE SIGNED Mar 30 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-1-59	
22c. NAME OF CEMETERY OR CREMATORIAL Fort Ashby Cemetery		22d. LOCATION (City, town, or county) (State) Fort Ashby W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Hafer Funeral Home		24a. REC'D BY REGISTRAR Arthur S. Thomas	
ADDRESS 23 E. Main, Frostburg, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	
DATE APR 2 '59			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PHA3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-tranit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02497

2505

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 10/13/1959					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Susan		First	Middle				
4. DATE OF DEATH Albright		Month	Day				
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/20/1880	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Laundry Worker, Laundry		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Levi Albright		14. MOTHER'S MAIDEN NAME Sophia Koontz					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT P.O. Box 599		Address Cumberland, Md.	
NO		NONE		Allegany County Infirmary Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocardial insufficiency INTERVAL BETWEEN ONSET AND DEATH ? 4222 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis ? DUE TO							
(c) Arthritis deformans ?							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Severe deterioration							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/1/52 , 19, to 3/6/59 , 19, that I last saw the deceased alive on 3/5/59 , 19, and that death occurred at 1:55 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 49 Green St.					
ACTUAL SIGNATURE <i>James E. McLean</i>		DATE SIGNED 3/6/59					
PHYSICIAN'S NAME (Type) Dr. James E. McLean		Cumberland, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 9, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Methodist Cem.		22d. LOCATION (City, town, or county) (State) Mt. Savage, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Md.		24a. REC'D BY REGISTRAR DATE MAR 9 '59					
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ST. MONTAINE - BIRDS FROM THE STATE OF MASSACHUSETTS

HTD TO STANISLAW

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02498

2506

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b RURAL and give nearest town Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND		d. STREET ADDRESS 1003 Harding Ave.,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1003 Harding Ave.,				d. STREET ADDRESS 1003 Harding Ave.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First HARRY	Middle WILLIAM	Lost ALDERTON	4. DATE OF DEATH Month March	Month 5,	Day 19	Year 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 26, 1907		9. AGE (In years last birthday) 51 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine operator		10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.		11. BIRTHPLACE (State or foreign country) Davis, W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Harry E. Alderton		14. MOTHER'S MAIDEN NAME Ellen Edwards							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-07-4982		17. INFORMANT Mrs. Helen A. Alderton		Address Cumberland, Md. 1003 Harding Ave.,			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o.) 420.1		<i>Coronary Thrombosis</i>		INTERVAL BETWEEN ONSET AND DEATH Subacute					
Conditions, if any, which gave rise to immediate cause (o.), stating the underlying cause lost. (b)		<i>Coronary Artery Disease</i>							
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 10-16-1959		(County) 3 - 5	(State) 1959
21. I certify that I attended the deceased from _____ alive on _____, 19_____, and that death occurred at _____, and that death occurred at 3:45A M , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) 122 So. Centre St.,		DATE SIGNED Arthur S. Thomas	
ACTUAL SIGNATURE <i>R. J. Williams</i>		PHYSICIAN'S NAME (Type) W. F. Williams M.D.		Cumberland, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/8/59		22c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park		22d. LOCATION (City, town, or county) Cumberland, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE MAR 9 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>			

STATE GOVERNMENT OF MARCH - 1940

CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in my event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02499

Reg. Dist. No.

2507

1. PLACE OF DEATH a. COUNTY Allegany	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	c. LENGTH OF STAY IN 1b Life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Constitution Park	d. STREET ADDRESS 242 N. Mechanic St.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) ROBERT	First C. Middle AMAN	4. DATE OF DEATH Month March Day 10 Year 1959					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> April 21, 1910	9. AGE (In years last birthday) 48 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meat Cutter	10b. KIND OF BUSINESS OR INDUSTRY A. & P. Market	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME George W. Aman, Sr.	14. MOTHER'S MAIDEN NAME Emma Mackart	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 214 05 5744	17. INFORMANT Address Mrs. Emma Aman, Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Cumberland	(County) Maryland	(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarelic	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED March 10, 1959			
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.	22b. DATE THEREOF 3/13/1959	22c. NAME OF CEMETERY OR CREMATORIUM St. Peter & Pauls Cem.	22d. LOCATION (City, town, or county) Cumberland, Md.	(State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight	ADDRESS Cumberland, Md.	24a. REC'D BY REGISTRAR Mar 16 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kline				

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2508

CERTIFICATE OF DEATH

03757

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 6 HRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,		e. STREET ADDRESS BEDFORD RT. #1 75X-3	
3. NAME OF DECEASED (Type or print) FIRST BABY BOY ARNOLD		4. DATE OF DEATH MARCH 23 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH MARCH 23, 1959
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME CHARLES D. ARNOLD	
14. MOTHER'S MAIDEN NAME MARILOU ARNOLD		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 761.5 DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Pregnancy - 32 weeks. electrolyte Partial separation of placenta	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) March 23, 1959	
20f. (City or town) CUMBERLAND, MD.		(County) (State)	
21. I certify that I attended the deceased from Mar 23, 1959 , to Mar 23, 1959 , that I last saw the deceased alive on Mar 23, 1959 , and that death occurred at 10:30 AM , from the causes and on the date stated above. ACTUAL SIGNATURE W.R. Hodges M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
22b. DATE THEREOF 3/24/59		22c. NAME OF CEMETERY OR CREMATORIAL Bedford Cemetery	
22d. LOCATION (City, town, or county) Bedford		(State) Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Givell		24a. REC'D BY REGISTRAR DATE MAY 1 1959	
ADDRESS Bedford, Pa.		24b. REGISTRAR'S SIGNATURE Arthur S. Tracy	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

51-1970-2A
NAME OF GENE - DATE OF GENE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02500

2586

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellerslie		c. LENGTH OF STAY IN lb Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS Ellerslie	
3. NAME OF DECEASED (Type or print) Charles L. Beal		4. DATE OF DEATH March 3, 1959	Month Day Year
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH Oct. 13, 1877	9. AGE (in years last birthday) 81 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad employee		11. BIRTHPLACE (State or foreign country) Penna. Railroad Palo Alto, Pa.	
13. FATHER'S NAME John Beal		14. MOTHER'S MAIDEN NAME Nancy Bennett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Violet Cooper. Ellerslie, Md.
		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial infarction DUE TO (c) Atherosclerotic Heart Disease		2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Urinary Gangrene Failure	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, M., from the causes and on the date stated above.			
ACTUAL SIGNATURE William R. James		ADDRESS (Street, city or town, state) 444 N. Main St. (3-5-55)	
PHYSICIAN'S NAME (Type) William R. James		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 6, 1959	22c. NAME OF CEMETERY OR CREMATORIUM Hyndman Cemetery
		22d. LOCATION (City, town, or county) Hyndman, Pennsylvania (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Harvey W. Zeigler,		ADDRESS Hyndman, Pa.	24a. REC'D BY REGISTRAR MAR 10 '59
		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar, or to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

400

111

DEATH

DEATH

DEATH

STATEMENT OF DEATH
SATURDAY, APRIL 27, 1968
IN THE CITY OF NEW YORK
BUREAU OF INVESTIGATION
DEPARTMENT OF POLICE
NEW YORK CITY
BY: [Signature]
Date: April 27, 1968
Time: 10:00 AM
Place: [Redacted]
Address: [Redacted]
Name: [Redacted]
Age: [Redacted]
Sex: [Redacted]
Race: [Redacted]
Height: [Redacted]
Weight: [Redacted]
Color of Hair: [Redacted]
Color of Eyes: [Redacted]
Occupation: [Redacted]
Employer: [Redacted]
Address: [Redacted]
Name of Next of Kin: [Redacted]
Address: [Redacted]
Relationship: [Redacted]
Phone Number: [Redacted]

WITNESS TO THIS STATEMENT

1

2

3

4

5

6

7

8

9

10

11

12

13

14

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5 A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2509

CERTIFICATE OF DEATH

02501

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 38 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND		d. STREET ADDRESS 50 WENPE DRIVE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First HELEN	Middle BERKENBAUGH	Last BERKENBAUGH	4. DATE OF DEATH MARCH 26	Month Day Year 19 59	
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 26, 1877	9. AGE (In years lost birthday) 82 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Nanking, MARYLAND		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME JAMES BERKAN (DECEASED)		14. MOTHER'S MAIDEN NAME CATHERINE Kane				Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT none		PATIENT'S CHART	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 33IX Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. } (b) DUE TO Right Cerebral Haemorrhage (c) DUE TO Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 17</u> , 1959, to <u>Mar 26</u> , 1959, that I last saw the deceased alive on <u>Mar. 25</u> , 1959, and that death occurred at <u>12:25 A.M.</u> from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED <u>Clay E. Durrett, M.D.</u> 236 Va. Avenue, Cumberland, Md. 3/26/59	
ACTUAL SIGNATURE <u>Clay E. Durrett</u>		PHYSICIAN'S NAME (Type)		M.D.		236 Va. Avenue, Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar 30, 1959		22c. NAME OF CEMETERY OR CREMATORIUM St. Mary's Catholic Cem		22d. LOCATION (City, town, or county) Cumberland, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		ADDRESS		24a. REC'D BY REGISTRAR MAR 30 '59 DATE		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

10250

01 3100 MITZAR - MITZAR ROTYEM 2004 190 37A72 01 10 1941

MITZAR TO STADT 1930

300

100

100

100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02502

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

V.S. A15ME
8M 2/57

2510

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 30 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HARRY D. BONNER		First HARRY	Middle D.
4. DATE OF DEATH March 1, 1959		Last BONNER	Month Day Year Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 21, 1911
9. AGE (in years last birthday) 47 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carmans Helper	
11. KIND OF BUSINESS OR INDUSTRY B. & O. R.R.		12. BIRTHPLACE (State or foreign country) WEST VIRGINIA	
13. FATHER'S NAME WILBERT BONNER		14. MOTHER'S MAIDEN NAME ARBELLA SMITH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 220 10 1212	
17. INFORMANT Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)	
		Coronary occlusion	
		Coronary Sclerosis	
		INTERVAL BETWEEN ONSET AND DEATH Sudden	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE Benedict Skitarelic	
EXAMINER'S NAME (Type) Benedict Skitarelic		DATE SIGNED 3/2/1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Mar. 4, 1959	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Sunset Memorial Park		22d. LOCATION (City, town, or county) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight		24a. REC'D BY REGISTRAR MAR 4 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Thorne	

PROFESSIONAL EXAMINER CERTIFICATION BEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2587 CERTIFICATE OF DEATH

02503

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Gills Hill		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) John R. Bradley		First	Middle	Last	4. DATE OF DEATH March 31 1959	Month	Day	Year			
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Nov 22, 1893	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.		
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>			10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Celenease Worker	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Lonaconing, Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Bradley				14. MOTHER'S MAIDEN NAME Martha Metz							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 1st W.W. 217-03-2157		17. INFORMANT Mrs. John Bradley		Address Lonaconing, Md.					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO 420.1		"Wife" Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH minutes					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Coronary anteriosclerosis		DUE TO (b)		Coronary anteriosclerosis		years					
		DUE TO (c)		Generalized arteriosclerosis		years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Moscow		(County)	(State)		
21. I certify that I attended the deceased from Oct 1957 to March 31, 1959 , that I last saw the deceased alive on Feb 28, 1959 , and that death occurred at 9 a M. from the causes and on the date stated above.										ADDRESS (Street, city or town, state) Moscow, Md.	DATE SIGNED 3-31-59
ACTUAL SIGNATURE Leslie R. Miles Jr.											
PHYSICIAN'S NAME (Type) Leslie R. Miles Jr. M.D. Lonaconing, Md.											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/3/59		22c. NAME OF CEMETERY OR CREMATORIUM Lanrel Hill Cemetery		22d. LOCATION (City, town, or county) Moscow		(State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lonaconing, Md.		24a. REC'D BY REGISTRAR DATE Apr 6 '59		24b. REGISTRAR'S SIGNATURE C. Eichhorn					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 could be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

87-39040-1A/FBI-MONTGOMERY STATE OF ALABAMA

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
257 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02504

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

O DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3.

O FUNERAL DIRECTOR: Page 3 may be retained for your files. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 7 days after death.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN lb Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		d. STREET ADDRESS 266 E. Main Street		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 266 E. Main Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Katherine		First	Middle	Last	4. DATE OF DEATH 3	Month	Day	Year
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH 10-15-1872	9. AGE (In years last birthday) 86 yrs.		IF UNDER 1YEAR Months Days Hours Min.		12. IF UNDER 24 HRS.
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				11. BIRTHPLACE (State or foreign country) Eckhart, Md.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Eckhart, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Patrick Brady				14. MOTHER'S MAIDEN NAME Honora Kenny				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No None				16. SOCIAL SECURITY NO. None 17. INFORMANT Mr. Joseph Spates, 270 E. Main, Frostburg, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b)				Coronary Thrombosis DUE TO cause lost. (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)				INTERVAL BETWEEN ONSET AND DEATH Sudden				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE W. M. Lane		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED Mar 27 1959		
EXAMINER'S NAME (Type) W. M. Lane MD ast		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-30-59		22c. NAME OF CEMETERY OR CREMATORIAL St. Michaels Cemetery		22d. LOCATION (City, town, or county) Frostburg		(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE Hafer Funeral Home ADDRESS 23 E. Main, Frostburg, Md.				24a. REC'D BY REGISTRAR APR 2 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas		

VS. A15MB
SM 2/57

卷之三

100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

02509

Reg. Dist. No.

2572

1. PLACE OF DEATH a. COUNTY <i>Allegany</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Allegany</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frostburg</i>		c. LENGTH OF STAY IN 1b <i>19 days</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Minors Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <i>Baby</i>	Middle <i>Bridges</i>	4. DATE OF DEATH Month <i>Mar 13</i> Year <i>1959</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar 12 1959</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>				
11. BIRTHPLACE (State or foreign country) <i>Mount Savage Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>				
13. FATHER'S NAME <i>Donald Bridges</i>		14. MOTHER'S MAIDEN NAME <i>Theresa Beeman</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>776X</i>		16. SOCIAL SECURITY NO. <i>—</i>				
17. INFORMANT <i>Theresa Bridges</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Prematurity</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>776X</i> (b) DUE TO (c)				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <i>2 dt 1959</i> <i>19 hrs</i>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>				
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>	20f. (City or town) <i>—</i>	(County) <i>—</i>	(State) <i>—</i>
21. I certify that I attended the deceased from <i>Mar 12</i> , 1959, to <i>Mar 13</i> , 1959, that I last saw the deceased alive on <i>Mar 13</i> , 1959, and that death occurred at <i>6:30P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>WOM Lane</i> PHYSICIAN'S NAME (Type) <i>WOM Lane MD</i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3-14-59</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Porter Cemetery</i>	22d. LOCATION (City, town, or county) <i>Eckhart</i>	(State) <i>Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE Hafer Funeral Home 23 E. Main, Frostburg, Md.			24a. REC'D BY REGISTRAR DATE <i>MAR 19 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hafer</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE ECONOMIST - 11 JUNE 2010 TRUMP AND THE STATE OF AMERICA

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02506

CERTIFICATE OF DEATH

Reg. Dist. No.

2511

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 50 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 61 Greene St.		d. STREET ADDRESS 61 Greene St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) JAMES ALVIN BRILL		First	Middle	Last	4. DATE OF DEATH March 5, 1959	Month	Day	Year 19
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 25, 1881	9. AGE (in years last birthday) 77	IF UNDER 1 YEAR Months 7	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Kirby, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME William A. Brill			14. MOTHER'S MAIDEN NAME Marian Satville					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 214 05 5894		17. INFORMANT Arthur Brill		Address Cumberland, Md.		
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under: ly ing cause lost. (b) extroblastic heart disease DUE TO (c) Generalized extroblastic 3 years</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) long history of emphysema (moderate) due to extroblastic disease</p> <p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 3-5-1959						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 51 Greene St.		20f. (City or town) (County) (State)		
<p>21. I certify that I attended the deceased from 1-3-, 1927, to 3-5-, 1959, that I last saw the deceased alive on 3-4-, 1959, and that death occurred at 4 P.M., from the causes and on the date stated above.</p> <p>ACTUAL SIGNATURE H. Kline</p> <p>PHYSICIAN'S NAME (Type) Byron Kight</p> <p>ADDRESS (Street, city or town, state) Cumberland, Md.</p> <p>DATE SIGNED 3-6-59</p>								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/9/1959		22c. NAME OF CEMETERY OR CREMATORIUM Sunset Memorial Park		22d. LOCATION (City, town, or county) Cumberland, Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE MAR 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Frank		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 24 hours after death.

4. ПРОМІСЯННЯ ВІДМІННОГО ВІДВІДУЧЕНОГО ПЛАТІЖУ ВАРЯГА

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PHM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02507

Reg. Dist. No.

2512

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland Sacred Heart Hospital		c. LENGTH OF STAY IN 1b 10 weeks	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) NORA E. BRINKER		First NORA	Middle E.
4. DATE OF DEATH MARCH 22		Last BRINKER	Month Day Year MARCH 22
5. SEX female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown
9. AGE (In years last birthday) 82	10. IF UNDER 1 YEAR Months 82	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Magnolia, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Boxell		14. MOTHER'S MAIDEN NAME Catherine Farrell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Kenneth Roby, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Pulmonary Edema and Congestion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Coronary Sclerosis DUE TO (c) Arteriosclerotic Cardiovascular disease, generalized			
INTERVAL BETWEEN ONSET AND DEATH 2-3 Wks.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fracture of Left Hip			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell at home	
20c. TIME OF INJURY Hour 11:00 a.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
20f. (City or town) Cumberland, Alleg. Md.		(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		DATE SIGNED March 22, 1959	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-35-59	
22c. NAME OF CEMETERY OR CREMATORIUM SS. Peter & Paul Cem.		22d. LOCATION (City, town, or county) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		ADDRESS	24a. REC'D BY REGISTRAR MAR 24 59
		DATE	24b. REGISTRAR'S SIGNATURE <i>John J. Kuhn</i>

31/12/1988
PENHILL

GENERAL INFORMATION	
NAME	JOHN HENRY
ADDRESS	1234 PENHILL
TELEPHONE NUMBER	01234 567890
DATE OF BIRTH	12/01/1965
SEX	MALE
RELIGION	CATHOLIC
EDUCATION	LEAVING CERTIFICATE
EMPLOYMENT	UNEMPLOYED
HOBBIES	FOOTBALL, GARDENING, DRIVING
INTERESTS	CRIME, POLICE, HISTORY
EXTRA INFORMATION	NO CHILDREN

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02508

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
o. COUNTY

2573

Allegany

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Frostburg

c. LENGTH OF STAY IN lb

2 Weeks

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

Miner's Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

John

W.

Broadwater

March

17th,

1959

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

Male

White

WIDOWED DIVORCED 9. AGE (In years
lost birthday)

10. IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

Dec. 27th, 1876

82 yrs.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Ret.-Laborer

10b. KIND OF BUSINESS OR INDUSTRY

W.P.A.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

John Broadwater

14. MOTHER'S MAIDEN NAME

Mary Custer

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

16. SOCIAL SECURITY NO.

INFORMANT

Address

213-18-2704 Mrs. Harry Haberlein, Eckhart, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

422.1

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

Artherosclerotic Cardiovascular Disease

INTERVAL BETWEEN
ONSET AND DEATH
2 years

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

NONE

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m.20d. INJURY OCCURRED
While Not while
of work of work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 3/12/59, 19, to 3/17/59, 19, that I last saw the deceased alive on 3/17/59, 19, and that death occurred at 1:30 A.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

Martin M. Rothstein, M.D.

PHYSICIAN'S
NAME (Type)

Martin M. Rothstein, M.D.

" " "

22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial

22b. DATE THEREOF

3-19-59

22c. NAME OF CEMETERY OR CREMATORIUM

Robison Cemetery

22d. LOCATION (City, town, or county)

(State)

Garrett County,

Md.

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Joseph R. Durst, Frostburg, Md.

24a. REC'D BY REGISTRAR

DATE MAR 20 '59

24b. REGISTRAR'S SIGNATURE

Arthur S. Thomas

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02509

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN lb 1 Wk.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midlothian		d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Ollie		First	Middle	Lost	4. DATE OF DEATH Cecil	Month 3	Day 19	Year 1959	
S. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 7-10-1907	9. AGE (In years lost birthday) 51 yrs.	IF UNDER 1 YEAR Months 5	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James Robertson				14. MOTHER'S MAIDEN NAME Ada Moore					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT William Cecil, Midlothian, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Cerebral Hemorrhage				INTERVAL BETWEEN ONSET AND DEATH 5 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Influenza -								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 9:30 P.M.							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 48 Broadway		(County) Midlothian	(State) Md.
21. I certify that I attended the deceased from 3/12/59 , 19, to 3/19/59 , 19, that I last saw the deceased alive on 3/19/59 , 19, and that death occurred at 9:30 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Midlothian, Md. ADDRESS (Street, city or town, state) 48 Broadway DATE SIGNED 3/26/59									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/21/59		22c. NAME OF CEMETERY OR CREMATORIAL Frostburg Memorial Park		22d. LOCATION (City, town, or county) Frostburg		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Reuben H. Montesant		ADDRESS Hafer Funeral Home 23 E. Main, Frostburg, Md.		24a. REC'D BY REGISTRAR Mar 26 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hafer			

OF BROMFELD--TELEGRAMS STATE CHAUSSE

HAEG TO STADTREED

1941 100 100

ZAHMEN

BAUER

WILHELM H. WILHELM H. WILHELM H.

0 0 2

T. T. (H. J.)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2513

CERTIFICATE OF DEATH

10251A

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 17 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL		d. STREET ADDRESS VINE PLACE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) EMMA		First M.	Middle CHISHOLM	Last 73	4. DATE OF DEATH MARCH 3 1959	Month MARCH	Day 3	Year 1959
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	8. DATE OF BIRTH July 26, 1885	9. AGE (In years lost birthday) 73 yrs.	10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JOHN RIEHL		14. MOTHER'S MAIDEN NAME MARTHA RUMPF		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-16-4681A 17. INFORMANT John F. Chisholm Cumberland, Md Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anteroseptal myocardial Infarction, recent, with congestive heart failure DUE TO Arteriosclerotic Heart Disease with cardiomegaly Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Genitourinary tract infection DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 weeks years		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.] Genitourinary tract infection		20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Cumberland (County) Maryland (State)
21. I certify that I attended the deceased from February 15, 1959 to March 3rd, 1959 , that I last saw the deceased alive on March 3rd, 1959 , and that death occurred at 5:25 p.m. from the causes and on the date stated above. ACTUAL SIGNATURE Wyand F. Doerner Jr. PHYSICIAN'S NAME (Type) Wyand F. Doerner, Jr., M.D.						ADDRESS (Street, city or town, state) Algonquin Hotel, Cumberland, Md. DATE SIGNED		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/6/59	22c. NAME OF CEMETERY OR CREMATORIUM RoseHill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox		ADDRESS Cumberland Maryland		24a. REC'D BY REGISTRAR DATE MAR 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Krause		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

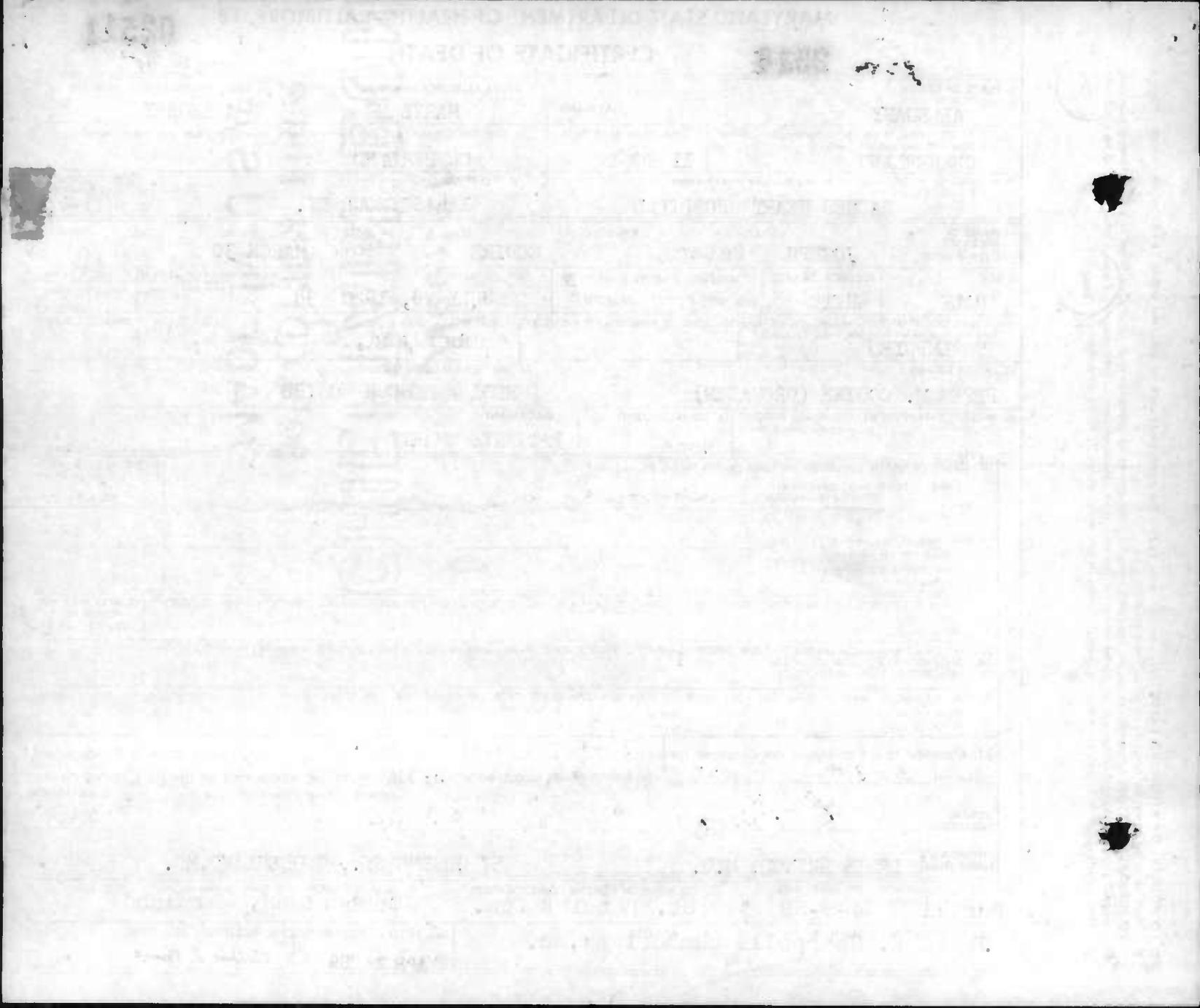
02511

2514

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 11 HOURS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First JOSEPH	Middle Peter	Last CODIRE
4. DATE OF DEATH	MARCH 30		Month Day Year 19 59
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 20, 1920
9. AGE (In years less birthday) 38 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNEMPLOYED	11. BIRTHPLACE (State or foreign country) Cumberland, Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME PETER M. CODIRE (DECEASED)	
14. MOTHER'S MAIDEN NAME REGINA MCHUGH CODIRE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None		INFORMANT PATIENTS CHART	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 340.3 DUE TO Meningitis INTERVAL BETWEEN ONSET AND DEATH 12 hours			
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) 57 Greene St. (County) Cumberland (State) Maryland
21. I certify that I attended the deceased from 3-29 , 19 57 , to 3-30 , 19 57 , that I last saw the deceased alive on 3-29 , 19 57 , and that death occurred at 8:00 AM , from the causes and on the date stated above. ACTUAL SIGNATURE L. Brings ADDRESS (Street, City or town, state) 57 Greene St. DATE SIGNED 3-30-59			
PHYSICIAN'S NAME (Type) LEWIS BRINGS, M.D.		22c. NAME OF CEMETERY OR CREMATORIUM St. Patrick Cem.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22d. LOCATION (City, town, or county) Cumberland, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.	24a. REC'D BY REGISTRAR DATE APR 2 '59
		24b. REGISTRAR'S SIGNATURE Arthur S. Thorne	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2515

CERTIFICATE OF DEATH

02512

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 114 Winton Place		d. STREET ADDRESS 114 Winton Place	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Harriet	Middle Elizabeth	Last Cooper
4. DATE OF DEATH Month March	Day 5	Year 1959	
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 8, 1878
9. AGE (In years last birthday) yrs. 80	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. KIND OF BUSINESS OR INDUSTRY Own home	12. BIRTHPLACE (State or foreign country) Harman, W. Va.
13. CITIZEN OF WHAT COUNTRY? U.S.A.	14. FATHER'S NAME Jacob C. Harper		
15. MOTHER'S MAIDEN NAME Susan McDonald	16. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] No, 17. SOCIAL SECURITY NO. None		
18. INFORMANT Mrs. Walter M. Fuller			Address Cumberland, 420 Beall St., Md.
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) DUE TO acute coronary occlusion extremular heart disease generalized arteriosclerosis			
INTERVAL BETWEEN ONSET AND DEATH 1/2 hour			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	Year
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 13-4 , 19 57 , to 3-5 , 19 57 , that I last saw the deceased alive on 3-5 , 19 57 , and that death occurred at 4:10 AM , from the causes and on the date stated above. ACTUAL SIGNATURE <i>L. Brings</i>			
ADDRESS (Street, city or town, state) 57 Greene St., M.D.			
DATE SIGNED 1			
PHYSICIAN'S NAME (Type) Lewis Brings M.D.			
Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/7/59	22c. NAME OF CEMETERY OR CREMATORIUM Harper Cemetery	22d. LOCATION (City, town, or county) (State) Harman, W. Va.
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Md.	24a. REC'D BY REGISTRAR DATE MAR 9 '59
			24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

STATEMENT OF EXPENSES
CERTIFICATE OF DEATH

RECEIVED
DEPARTMENT OF HOMELAND SECURITY
FEBRUARY 10, 2008

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2516

CERTIFICATE OF DEATH

02513

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 will be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 14 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL AND WARWICK AVENUE		e. STREET ADDRESS 633 MARYLAND AVENUE	
3. NAME OF DECEASED (Type or print) LILLIAN PEARL		Last CORNWELL	4. DATE OF DEATH MARCH 7 1959
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 8, 1893
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Doy Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY At home	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME IRA THOMAS HITE		14. MOTHER'S MAIDEN NAME EMMA FADLEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b) Coronary Thrombosis 1 day DUE TO (c) Coronary Artery Disease —	
19. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State) —	
21. I certify that I attended the deceased from 4/20/59 , 19, to 4/21/59 , 19, that I last saw the deceased alive on 4/21/59 , 19, and that death occurred at 1:30 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE B. J. Hillcox ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 4/21/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/10/59	
22c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox		ADDRESS Cumberland Maryland	
24a. REC'D BY REGISTRAR DATE MAR 11 '59		24b. REGISTRAR'S SIGNATURE Christine S. Krause	

21 DEPARTMENT OF TRANSPORTATION STATE OF KANSAS

STATE HIGHWAY DEPARTMENT

YARD 643

571 C 1002 421

JAN 10 1900

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02514

Reg. Dist. No.

2575

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN lb c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> Lonaconing	
3. NAME OF DECEASED (Type or print) William		First William	Middle Cuthbertson
4. DATE OF DEATH March 19 1959	Month March	Day 19	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 19, 1900
9. AGE (In years lost birthday) 58 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Celanese Worker	11. KIND OF BUSINESS OR INDUSTRY Celanese Corp	12. BIRTHPLACE (State or foreign country) Lonaconing, Maryland
13. FATHER'S NAME William Cuthbertson	14. MOTHER'S MAIDEN NAME Elizabeth Park	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. 220-10-23564		17. INFORMANT Mrs. William Cuthbertson	Address Lonaconing, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 292.3 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Mesenteric Thrombosis		"Wife"	INTERVAL BETWEEN ONSET AND DEATH 1 week
(c) DUE TO Recurrent Phlebitis			3 years
(c) DUE TO Agranogenic Myeloid Metaplasia			7 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 1956 to March 1959 , that I last saw the deceased alive on March 19 1959 , and that death occurred at 9 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) LONA CONING DATE SIGNED 3-20-59			
ACTUAL SIGNATURE Leslie R. Miller Jr.		M.D.	
PHYSICIAN'S NAME (Type) LESLIE R. MILLER JR		LONA CONING MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/22/59	22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery
22d. LOCATION (City, town, or county) Lonaconing, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lonaconing, Md.	24a. REC'D BY REGISTRAR DATE MAR 23 '59
		24b. REGISTRAR'S SIGNATURE Arthur L. Evans	

MISSOURI STATE DEPARTMENT OF REVENUE - 18

CERTIFICATE OF DEATH

1710



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

02515

Reg. Dist. No.

2517

Items 8, Film G240 4-6-59 et

Item 9 Film G240 3-20-59 et

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 shall be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Hagerstown</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cumberland</i>		c. LENGTH OF STAY IN 1b RURAL and give nearest town <i>02 Cumberland</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>119 Bedford St.</i>		e. STREET ADDRESS <i>119 Bedford St.</i>	
3. NAME OF DECEASED (Type or print) <i>Robert</i>		First <i>Louis</i>	Middle <i>Davids</i>
4. DATE OF DEATH <i>March 11 1959</i>		Last <i>1889</i>	Month <i>Oct. 26</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1889</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Eng. in Ordnance Dept</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U. S. Army</i>	11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>
13. FATHER'S NAME <i>Henry Davids</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Kehrn</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>420.1</i>		16. SOCIAL SECURITY NO. <i>578-32-8777</i>	17. INFORMANT <i>Elva M. Davids</i>
		Address <i>119 Bedford St. Cumberland Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ADDRESS (Street, city or town, state) <i>300A</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>Mar. 10, 1959</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State) <i>236 24. Cor Cumberland</i>
21. I certify that I attended the deceased from <i>Jan. 5, 1959</i> to <i>Mar. 11, 1959</i> , that I last saw the deceased alive on <i>Mar. 10, 1959</i> , and that death occurred at <i>3:00 A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Clayton Bennett</i> ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) <i>M.D.</i> DATE SIGNED <i>3/13/59</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Mar. 13, 1959</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Loudon Park Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Louis Stein, Inc. Cumberland, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>MAR 16 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02516

2576

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 10 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miner's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Mary	Middle C.	Last Delaney
4. DATE OF DEATH	Month March	Day 18th, 19	Year 59
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 4th, 1891
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Housework	
10c. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Reilly		14. MOTHER'S MAIDEN NAME Sarah Malloy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 214-01-3657A	
		INFORMANT John A. Delaney, RD 3, F'bg., Md. Box 61	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/18 , 19 59 , to March 18, 19 59 at I last saw the deceased alive on March 18 , 19 59 , and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Hilda Jane Walters</i>		ADDRESS (Street, city or town, state) 48 Broadway, Frostburg, Md.	
DATE SIGNED 3/20/59			
PHYSICIAN'S NAME (Type) Hilda Jane Walters,		M.D. " "	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-21-59	22c. NAME OF CEMETERY OR CREMATORIUM St. Michael's Cemetery	22d. LOCATION (City, town, or county) Frostburg,
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst, Frostburg, Md.		24a. REC'D. BY REGISTRAR MAR 23 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Thorne	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02517

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 24 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		e. STREET ADDRESS 1456 Williams St.	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JESSE EARL DeVORE		First	Middle
4. DATE OF DEATH March 16 1959	Month	Doy	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 8, 1882
9. AGE (In years last birthday) 76 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Signalman		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John DeVore		14. MOTHER'S MAIDEN NAME Barbara Witt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 705 05 1809	
17. INFORMANT Mrs. Sarah DeVore		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Arteriosclerotic C-V Disease INTERVAL BETWEEN ONSET AND DEATH 4-5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of left hip		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. X		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell At Home	
20c. TIME OF INJURY Hour 2:15 p.m. 3/8/59 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Cumberland, Alleg. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>	DATE SIGNED March 17, 1959		
EXAMINER'S NAME (Type) Benedict Skitarelic M. D.	CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/18/1959	22c. NAME OF CEMETERY OR CREMATORIUM Hilcrest Cemetery	22d. LOCATION (City, town, or county) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight		ADDRESS Cumberland, Md.	24a. REC'D BY REGISTRAR MAR 19 '59
			24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 FilmG240 3-30-59 et

02518

2519

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pinty Md Cumberland		c. LENGTH OF STAY IN 1b 12 hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital-D.O.A. Allegany Ballistics		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
3. NAME OF DECEASED (Type or print) Reese		First Irvin	Middle Diehl
4. DATE OF DEATH March 18 1959		Lost	Month Day Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 1, 1908
9. AGE (In years from birth) 50		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telephone installer-		10b. KIND OF BUSINESS OR INDUSTRY Cumberland, Md	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Frank I. Diehl		14. MOTHER'S MAIDEN NAME Carrie Mae Robertson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-05-0785	17. INFORMANT Mrs. Marie Diehl 407 Linden, St. Cumberland, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 420.1		INTERVAL BETWEEN ONSET AND DEATH Unknown	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c)		Coronary Thrombosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED White Nat while at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____		21. I certify that I attended the deceased from June 24, 1959 to 3-18-1959 , that I last saw the deceased alive on 3-14-1959 , and that death occurred at 10 a.m. from the causes and on the date stated above. ADDRESS (Street, city or town, State) Dr. Wm. L. Williams, M.D., Cumberland, Md.	
ACTUAL SIGNATURE		DATE SIGNED 3/18/59	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/21/59	22c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park
22d. LOCATION (City, town, or county) Cumberland		(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox		24a. REC'D BY REGISTRAR DATE MAR 23 '59	24b. REGISTRAR'S SIGNATURE Charles S. Trahan

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G240 3-24-59 et

02519

2577

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		c. LENGTH OF STAY IN lb 4 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 135 Front		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport 43	
3. NAME OF DECEASED First Verna Middle Mae Doman		d. STREET ADDRESS 135 Front	
(Type or print)		4. DATE OF DEATH Mar. 18 1959	Month Day Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH July 5, 1901
8. AGE (In years last birthday) 57 58 yrs.		9. IF UNDER 1 YEAR Months Days	10. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph S. Teets		14. MOTHER'S MAIDEN NAME Rebecca Hutzel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. 17. INFORMANT Address Howard Doman-Westernport, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 199.2 DUE TO Carcinoma of Uterus and Rectum		12 yrs	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Carcinomatosis., (c)		5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____ to _____, 19____ that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <i>Hill Teeter Jr.</i>		Piedmont W Va	
PHYSICIAN'S NAME (Type) James H. Wolverton Sr Md		Piedmont W Va	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/21/59	
22c. NAME OF CEMETERY OR CREMATORIUM George Cemetery		22d. LOCATION (City, town, or county) Swantown (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>E. Bur</i>		ADDRESS Westernport, Md.	
		24a. REC'D BY REGISTRAR DATE MAR 20 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kress

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02520

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

M
00
1
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1		2520										02520			
1. PLACE OF DEATH		a. COUNTY Allegany			MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		C. LENGTH OF STAY IN lb Cumberland			d. STREET ADDRESS life			a. STATE Maryland		b. COUNTY Allegany		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		117 Independence St.			d. STREET ADDRESS 117 Independence St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First CHARLES			Middle M			4. DATE OF DEATH MARCH 27 1959		Month M		Doy 27		Year 19 59	
5. SEX		6. COLOR OR RACE Male		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH White		9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR Months 49		11. IF UNDER 24 HRS. Days 0		12. IF UNDER 24 HRS. Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY laborer		11. BIRTHPLACE (State or foreign country) Bakery		Maryland		12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME Charles L. Eirich Emma Crutchley													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214 05 9296		17. INFORMANT Mrs. Inez Eirich		Address Cumberland, Md.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		19. INTERVAL BETWEEN ONSET AND DEATH 3-4 days													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Myocardial Infarction													
420.1 DUE TO		3-4 days													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.		(b)		Coronary Occlusion, right											
DUE TO		(c)		Coronary Sclerosis, right											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		Pulmonary embolism from mural thrombus													
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Moorefield, W. Va.		(County) Moorefield, W. Va.		(State) W. Va.			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED March 27, 1959									
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>													
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/30/1959		22c. NAME OF CEMETERY OR CREMATORIUM Asbury Cemetery		22d. LOCATION (City, town, or county) Moorefield, W. Va.		(State) W. Va.							
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR MAR 31 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Krause									

WISCONSIN STATE EDUCATIONAL CREDIT FUND

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7, Film G240, 3/23/59, pcy

02521

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		b. COUNTY Allegany	
c. LENGTH OF STAY IN lb Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 125 East Main		d. STREET ADDRESS 125 E. Main	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Nellie		First V.	Middle Fisher
4. DATE OF DEATH 3 14 19 59	Month 3	Day 14	Year 19 59
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-10-1874
9. AGE (In years lost birthday) 84 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months 84	Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Eckhart, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John A. McMullen		14. MOTHER'S MAIDEN NAME Mary V. Jordan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Mr. Jackson Fisher, Consolidation Village
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address Frostburg, Md.	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac dilatation		INTERVAL BETWEEN ONSET AND DEATH Sudden	
422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Chr-myocardial insufficiency		8-9 years	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Senility		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June , 19 59 , to 3-14 , 19 59 that I last saw the deceased alive on 3-4 , 19 59 , and that death occurred at 8 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 39 W. MAIN ST., FROSTBURG, Md.	
ACTUAL SIGNATURE H.C. Diehl, M.D.		DATE SIGNED 3/17/59.	
PHYSICIAN'S NAME (Type) H.C. Diehl, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-17-59	22c. NAME OF CEMETERY OR CREMATORIAL Eckhart Cemetery
22d. LOCATION (City, town, or county) Eckhart,		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hafer Funeral Home		24a. REC'D BY REGISTRAR DATE MAR 19 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Evans
ADDRESS 23 E. Main, Frostburg, Md.			

MATERIALS STATE DEPARTMENT OF HEALTH - ALABAMA

CERTIFICATE OF DEATH

ALABAMA

JULY 1944

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02522

2521

CERTIFICATE OF DEATH

Reg. Dist. No.

1		TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.	
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.		2	
1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Viola		Middle M.	
4. DATE OF DEATH March 16th 1959		Lost Month Year	
5. SEX Female		6. COLOR OR RACE white	
7. MARRIED X		NEVER MARRIED <input type="checkbox"/>	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Jan 23,		9. AGE (In years lost 64 birthday) yrs. 64	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Adam Spoerl		14. MOTHER'S MAIDEN NAME Clara Connors	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Pt's chart- Husband		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Occlusion, Right Coronary Artery			
DUE TO 420.1			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Hypertensive and Arteriosclerotic Heart			
DUE TO disease, with cardiomegaly & old massive anterior myocardial infarction			
C 13 months			
INTERVAL BETWEEN ONSET AND DEATH minutes			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
Acute Obstruction of Sigmoid Colon, due chronic diverticulitis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Doy, Year Hour o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 25, 58 , to March 16th 1959 , that I last saw the deceased alive on March 16th 1959 , and that death occurred at 9:55 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Algonquin Hotel, DATE SIGNED Arthur S. Krause			
ACTUAL SIGNATURE <i>Wyand F. Doerner Jr.</i>		M.D.	
PHYSICIAN'S NAME (Type) Wyand F. Doerner, Jr., M.D.		Cumberland, Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 19, 1959	
22c. NAME OF CEMETERY OR CREMATORIUM St Peter + Paul Cem		22d. LOCATION (City, town, or county) Cumberland MD	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Louis Stein Inc.</i>		ADDRESS Cumberland MD	
24a. REC'D BY REGISTRAR DATE MAR 20 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>	

CERTIFICATE OF DEATH

STATE OF MICHIGAN

DEPARTMENT OF STATE

REGISTRATION

RECEIVED

SEARCHED

INDEXED

SERIALIZED

FILED

SEARCHED

INDEXED

SERIALIZED

FILED



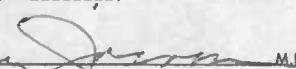
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02523

2522

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LONACONING			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL AND WARWICK AVENUES				d. STREET ADDRESS BOX 214		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First EDNA	Middle M	Last FOOTE	4. DATE OF DEATH	Month MARCH	Day 2	Year 19 59
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 28, 1898	9. AGE (In years lost birthday) 61 yrs.	IF UNDER 1 YEAR Months 6	IF UNDER 24 HRS. Days 1	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) WESTERNPORT, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY DAYTON				14. MOTHER'S MAIDEN NAME EMMA DAWSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia, hepatic coma DUE TO 581.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Portal Cirrhosis of liver DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Post hemorrhagic anemia due to ruptured esophageal varices						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 1, 19 59 to March 2, 19 59 , that I last saw the deceased alive on March 2, 19 59 , and that death occurred at 2:25 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 50 Pershing St., Cumberland, Maryland							
ACTUAL SIGNATURE 		DATE SIGNED 2/4/59					
PHYSICIAN'S NAME (Type) Samuel M. Jacobson, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/5/59		22c. NAME OF CEMETERY OR CREMATORIUM Oak Hill Cemetery		22d. LOCATION (City, town, or county) Lonaconing	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lonaconing, Md.		24a. REC'D BY REGISTRAR DATE MAR 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Trahan	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WISCONSIN STATE DEPARTMENT OF HEALTH - COLUMBIA 18

CERTIFICATE OF DEATH

DEATH NO.

NAME

MATERIAL

SEX

AGE

CAUSE

TIME

PLACE

TIME

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar [P.D.] for a burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02524

2523

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 7 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hillcrest Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ALICE		First GERTRUD	Middle GOODWIN
Last Retired		4. DATE OF DEATH March 15	Month Day Year 1959
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH December 23, 1882		9. AGE (In years last birthday) yrs. 76	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Registered Nurse	
11. BIRTHPLACE (State or foreign country) Finzel, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Finzel (Deceased)		14. MOTHER'S MAIDEN NAME Sarah McKenzie (Deceased)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 420.0	
17. INFORMANT Mrs. Arthur Hawkins			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Cardiac Failure		INTERVAL BETWEEN ONSET AND DEATH 4 days	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic Heart Disease		5 years	
DUE TO (c) Generalized arterosclerosis		?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Parkinson's Syndrome		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 15 March 1959 to 15 March 1959 , that I last saw the deceased alive on 15 March 1959 , and that death occurred at 5:40 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 122 South Center St. Cumberland, Md.	
ACTUAL SIGNATURE W. Alfred VanOrmer		DATE SIGNED 3/17/59	
PHYSICIAN'S NAME (Type) Alfred VanOrmer M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 18, 1959	
22c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR DATE MAR 19 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Albert S. Evans	

CERTIFICATE OF DEATH

11



Fred J. Murdoch
Baltimore

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02525

Reg. Dist. No.

Allegany

2524

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY

Allegany

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

c. LENGTH OF STAY IN lb

66 days.

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE

b. COUNTY

Maryland

Allegany

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

43 Westernport

d. STREET ADDRESS

104 Main St.

e. IS RESIDENCE ON A FARM?

YES NO 3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATHMonth
March
2,Day
Year
1959

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years
last birthday)
69IF UNDER 1 YEAR
Months Days Hours Min.

Female

White

WIDOWED DIVORCED

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

house-wife

10b. KIND OF BUSINESS OR INDUSTRY
own home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William Hammers

14. MOTHER'S MAIDEN NAME

Address

Chart

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

199.1

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

6 months

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m.20d. INJURY OCCURRED
White Not white
at work of work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 1-4, 1959, to 3-2, 1959, that I last saw the deceased alive on 3-2, 1959, and that death occurred at 4 P.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED
3-3-59ACTUAL
SIGNATURE

Pars Brings

M.D.

57 Green St.

PHYSICIAN'S
NAME (Type)

LEWIS BRINGS

Cumberland Md.

22a. BURIAL, CREMATION,
REMOVAL (Specify)
burial22b. DATE THEREOF
3/15/59

22c. NAME OF CEMETERY OR CREMATORIUM

St. Peters Cemetery

22d. LOCATION (City, town, or county)

Westernport, Md.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

W.H. Murdoch Jr.

Piedmont, W.Va.

24a. REC'D BY REGISTRAR
DATE MAR 5 '59

DATE

24b. REGISTRAR'S SIGNATURE

Arthur S. Krause

STATE OF DELAWARE
DEPARTMENT OF HEALTH - BEAUTY



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02526

2525

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 20 minutes		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL		d. STREET ADDRESS 1310 PIEDMONT AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First WALTER	Middle L.	Last HARDMAN	4. DATE OF DEATH	Month MARCH	Day 13	Year 19 59		
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 12-17-99	9. AGE (In years lost/birthday) 59 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stockman		10b. KIND OF BUSINESS OR INDUSTRY Merchants Wholesale		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA, Bedford County		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME CLINTON HARDMAN (Deceased)			14. MOTHER'S MAIDEN NAME Bessie Hardman (Deceased)			Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-05-6260		17. INFORMANT CHART		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1			DUE TO Stute coronary occlusion			INTERVAL BETWEEN ONSET AND DEATH 4 hours			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)			DUE TO coronary sclerosis			18 years			
(c) DUE TO generalized arteriosclerosis						2 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 57 Greene Street		(County) Cumberland	(State) Md.
21. I certify that I attended the deceased from 3-1-1958 to 3-13-1959 that I last saw the deceased alive on 3-13-1959 , and that death occurred at 5:20 P.M. from the causes and on the date stated above.									
ACTUAL SIGNATURE L Brings									
PHYSICIAN'S NAME (Type) LEWIS BRINGS, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/16/59		22c. NAME OF CEMETERY OR CREMATORIUM Hillcrest Burial Prk		22d. LOCATION (City, town, or county) Cumberland, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE MAR 19 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

THE STATE OF VERMONT - HANOVER - 18

CERTIFICATE OF DEATH



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G240 3-24-59 et

02527

Reg. Dist. No.

2526

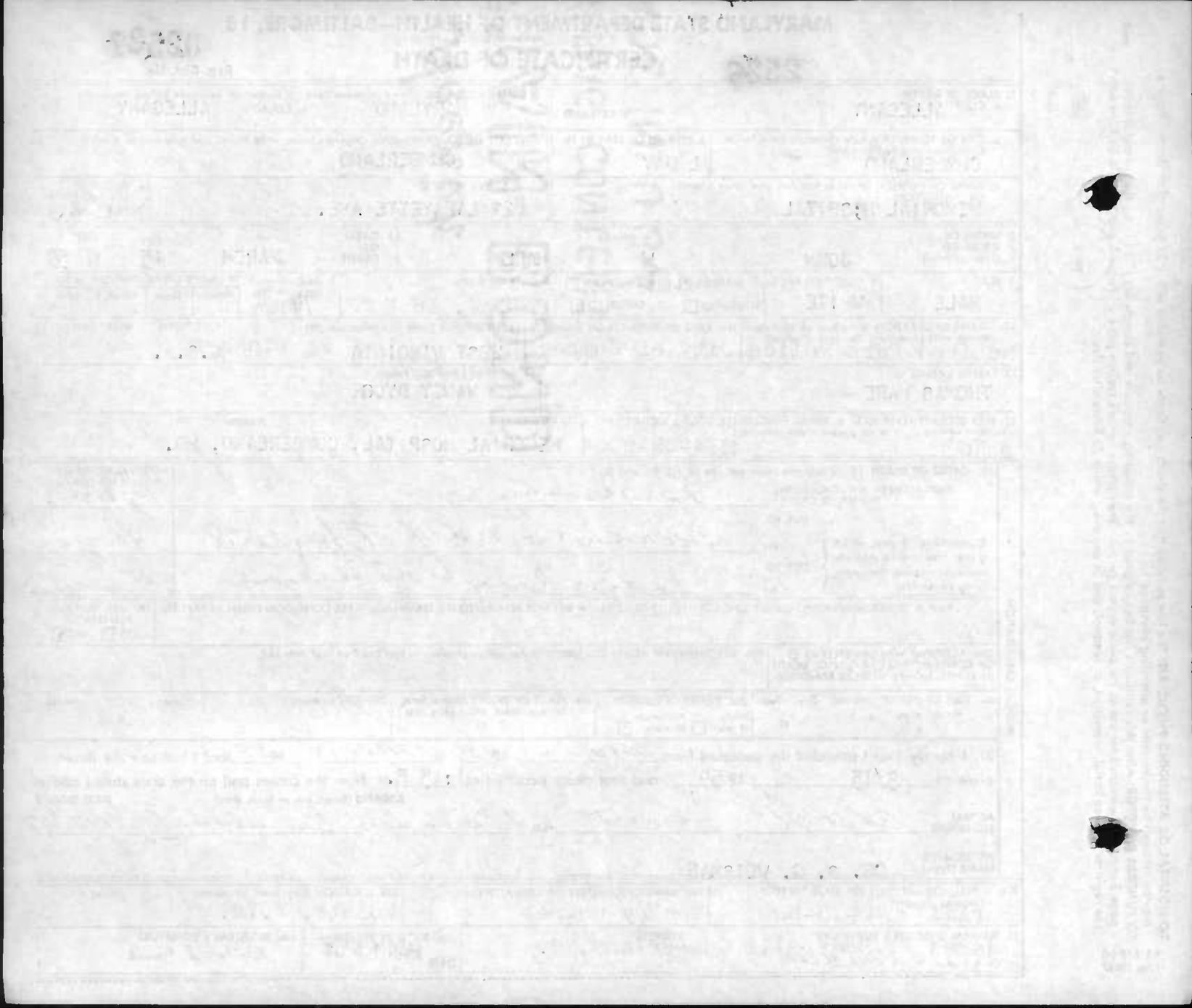
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb L DAY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. STREET ADDRESS 1823 LAFAYETTE AVE.	
3. NAME OF DECEASED First JOHN Middle W HARE		4. DATE OF DEATH Month MARCH Day 15 Year 1959	
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 4, 1884
		DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 77 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Park Police		10b. KIND OF BUSINESS OR INDUSTRY City of Cumberland	11. BIRTHPLACE (State or foreign country) WEST VIRGINIA
		12. CITIZEN OF WHAT COUNTRY? Martinsburg U.S.A.	
13. FATHER'S NAME THOMAS HARE		14. MOTHER'S MAIDEN NAME NANCY DYCE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-05-9234 17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 194X DUE TO Thrombosis			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO Carcinoma of Thyroid 4 yrs			
Secondary Anæmia 4 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Apr. 10, 1959, to Mar. 15, 1959, that I last saw the deceased alive on 3/15, 1959, and that death occurred at 1:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE DR. S. G. WEISMAN DATE SIGNED 3/18/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-18-59	22c. NAME OF CEMETERY OR CREMATORIUM Wesley Chapel
22d. LOCATION (City, town, or county) Points, W.Va. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.	24a. REC'D BY REGISTRAR MAR 19 '59
			DATE
			24b. REGISTRAR'S SIGNATURE Arthur S. Hause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2527

CERTIFICATE OF DEATH

02528

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND		b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 38 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL, MEMORIAL AVE.		d. STREET ADDRESS 71 GREENE ST		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Mr. Newton ETON B. HEIMS		First	Middle	Last	4. DATE OF DEATH MARCH 1 19 59	Month	Day	Year	
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/25/80	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor		10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME CHARLES Heims		14. MOTHER'S MAIDEN NAME CLARA Leedy							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease with cardiomegaly, several yrs 420.0 DUE TO old myocardial infarct, congestive failure and									
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO myocardial degeneration									
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Pyelonephritis with early uremia; Occlusion, rt. popliteal art.									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from June 1958 to March 1, 1959 that I last saw the deceased alive on March 1st, 1959 , and that death occurred at 12:10 P.M. from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) Algonquin Hotel									
DATE SIGNED 3/3/59									
ACTUAL SIGNATURE <i>Newton B. Doerner</i>		M.D.							
PHYSICIAN'S NAME (Type) DR. WYAND DOERNER		ALGONQUIN HOTEL, CUMBERLAND, MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/3/59		22c. NAME OF CEMETERY OR CREMATORIUM Umbria Cemetery		22d. LOCATION (City, town, or county) Osceola Mills, Penna.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE MAR 4 '59		24b. REGISTRAR'S SIGNATURE Cynthia S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE STATE OF HAWAII - DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

NAME OF DECEASED	AGE	SEX	DEATH DATE	TIME	CAUSE OF DEATH	DEATH CERTIFICATION
JOHN DOE	45	M	12/12/1999	10:00 AM	HEART DISEASE	APPROVED
ADDRESS						
CITY, STATE, ZIP						
PHONE NUMBER						
RELATIONSHIP TO DECEASED						
SIGNATURE						
DATE						

02529

Reg. Dist. No.

2579

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE		Maryland		b. COUNTY	
Allegany				Maryland		Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 3 Mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Savage		d. STREET ADDRESS Glen Savage Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miner's Hospital									
3. NAME OF DECEASED (Type or print)	First Emma	Middle C.	Last Henckel	4. DATE OF DEATH	Month March	Day 13th	Year 1959		
S. SEX	6. COLOR OR RACE Female	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH April 18th, 1873	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY own housework		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Valentine Henckel		14. MOTHER'S MAIDEN NAME Catherine Snyder							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT Miss Edna Henckel, Mt. Savage, Md.		Address			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X		DUE TO <i>Cerebral Hemorrhage</i>		INTERVAL BETWEEN ONSET AND DEATH 2 mo					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)		DUE TO <i>Arteriosclerosis</i> (c)		General years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY	Month, Doy, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)			
Hour a. m. p. m.	19	While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
21. I certify that I attended the deceased from Mar 13 , 1959, to Mar 13 , 1959, that I last saw the deceased alive on Mar 13 , 1959, and that death occurred at 7:45 AM , from the causes and on the date stated above.						ADDRESS (Street, city or town, state)			DATE SIGNED
ACTUAL SIGNATURE W. O. McLane		M.D.		E. Main St., Frostburg, Md.				Mar 13 1959	
PHYSICIAN'S NAME (Type) W. O. McLane,		M.D. " " "							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-16-59		22c. NAME OF CEMETERY OR CREMATORIY St. Patricks Cemetery		22d. LOCATION (City, town, or county) Mt. Savage,		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst, Frostburg, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE MAR 17 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02530

2528

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 8/5/58				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) John		First A.	Middle Hendrickson			
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 11/10/1875			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Foreman		10b. KIND OF BUSINESS OR INDUSTRY Md. State Roads	11. BIRTHPLACE (State or foreign country) Maryland			
13. FATHER'S NAME WILLIAM HENDRICKSON		14. MOTHER'S MAIDEN NAME MARTHA HUFF				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	17. INFORMANT P.O. Box 599 Allegany County Infirmary Records			
Address Cumberland, Md.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						
<i>Ischaemic Sclerosis,</i> ? <i>Chronic myocardial degeneration</i> ? <i>Cerebral arteriosclerosis</i> ?						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Senile Deterioration						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 49 Greene St.	20f. (City or town) Cumberland	(County) Md.	(State) MD
21. I certify that I attended the deceased from 8/5/58 , 19, to 3/15/59 , 19, that I last saw the deceased alive on 3/14/59 , 19, and that death occurred at 5:30 P.M. , from the causes and on the date stated above.						
ACTUAL SIGNATURE <i>James E. McLean</i>				ADDRESS (Street, city or town, state) 49 Greene St.		
PHYSICIAN'S NAME (Type) Dr. James E. McLean				DATE SIGNED 3/16/59		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/18/59	22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE MAR 19 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATEMENT OF DEATH - FORM NO. 1

CERTIFICATE OF DEATH

NAME

NAME

NAME

NAME

5. OCCUPATION

6. PLACE OF BIRTH

7. DATE OF BIRTH

8. DATE OF DEATH

9. PLACE OF DEATH

10. CAUSE OF DEATH

11. MANNER OF DEATH

12. TIME OF DEATH

13. AGE AT DEATH

14. GENDER

15. RACE

16. RELIGION

17. EDUCATION

18. OCCUPATION

19. MARRIED

20. CHILDREN

21. PARENTS

22. SIBLINGS

23. NEAREST RELATIVES

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2529

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02531

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY	Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			a. STATE Maryland b. COUNTY Allegany
Cumberland,			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS
407 Beall St.,			1407 Beall St.,

3. NAME OF DECEASED (Type or print)	First Annette	Middle	Last Hensel	4. DATE OF DEATH	Month MARCH	Doy 1, 19 59	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
--	---------------	--------	-------------	------------------	-------------	--------------	---

5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Nov. 13, 1879			

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Linen folder	Hosp. Laundry	Leisenring, Penna.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
George Hensel	Ann Prinkey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address Hyattsville, Md.
No,	None	Mrs. C. F. Purdham,	5009 54th Rogers Hts

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	SUDDEN
420.1 CORONARY OCCLUSION	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
(b) CORONARY SCLEROSIS	
(c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
---	---

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>

ACTUAL SIGNATURE <i>Benedict Skitarelic</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	DATE SIGNED March 3, 1959
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/6/59	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olive Cemetery	22d. LOCATION (City, town, or county) Connellsville, Penna. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George	ADDRESS Cumberland, Md.	24a. REC'D BY REGISTRAR DATE MAR 6 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Krause

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2530

CERTIFICATE OF DEATH

02532

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md.		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland Maryland		c. LENGTH OF STAY IN lb 5 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland, Maryland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		d. STREET ADDRESS 210 Knox St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Sarah		First E.	Middle Higgins	Lost March	4. DATE OF DEATH 22nd	Month 19	Day 59
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 3-1-1885	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months 0		IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired School		10b. KIND OF BUSINESS OR INDUSTRY Public Schools		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME James Higgins		14. MOTHER'S MAIDEN NAME Mary Douglas Higgins		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Charles Marks		18. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Arteriosclerotic and coronary heart disease DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. (b) DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		INTERVAL BETWEEN ONSET AND DEATH 6 years	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 3 - 18, 1957		20f. (City or town) (County) (State) 3 - 22, 1959	
21. I certify that I attended the deceased from 3 - 18, 1957 to 3 - 22, 1959 , that I last saw the deceased alive on 3 - 22 - 1959 , and that death occurred at 1:00 P.M. from the causes and on the date stated above.		ACTUAL SIGNATURE Reya W. Ballin		ADDRESS (Street, city or town, state) 62 Greene St.		DATE SIGNED 3-23-59	
PHYSICIAN'S NAME (Type) Dr. R. W. Ballin		22b. DATE THEREOF 3/25/1959		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
22e. BURIAL, CREMATION, REMOVAL (Specify) Burial		24a. REC'D BY REGISTRAR MAR 26 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			
23. FUNERAL DIRECTOR'S SIGNATURE Byron Knight		ADDRESS Cumberland, Md.					

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02538

2588

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eckhart		c. LENGTH OF STAY IN 1b Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eckhart		d. STREET ADDRESS /		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Anna		First	Middle	Last	4. DATE OF DEATH March 14th, 1959	Month	Day	Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH May 5th, 1879	9. AGE (In years lost birthday) 79 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hous ewife		10b. KIND OF BUSINESS OR INDUSTRY own Housework		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Louis Kimberley		14. MOTHER'S MAIDEN NAME Lucinda Porter						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT		Address Mrs. Ruth Snyder, Eckhart, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) DUE TO		<i>Arteriosclerosis</i> <i>Cerebral Hemorrhage</i>				INTERVAL BETWEEN ONSET AND DEATH 6 mo		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) fall				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 167 E. Main St., F'bg., Md.		(County) (State)
21. I certify that I attended the deceased from May 16, 1957 , to March 14, 1959 that I last saw the deceased alive on Feb 21, 1959 , and that death occurred at 9:30 AM , from the causes and on the date stated above. ACTUAL SIGNATURE W. O. McLane						ADDRESS (Street, city or town, state) Mark		DATE SIGNED
PHYSICIAN'S NAME (Type) W. O. McLane,		M.D. " " " " "						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-17-59		22c. NAME OF CEMETERY OR CREMATORIUM Eckhart Cemetery		22d. LOCATION (City, town, or county) Eckhart, Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst, Frostburg, Md.		ADDRESS		24a. REC'D BY REGISTRAR Cathleen S. Durst		24b. REGISTRAR'S SIGNATURE Cathleen S. Durst		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

02534

Reg. Dist. No.

2531

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 5/20/57	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> d. STREET ADDRESS Rt.#1, Vale Summit	
3. NAME OF DECEASED (Type or print)	First Crawford	Middle S. Hoblitzell	Last Month Day Year 4. DATE OF DEATH March 22, 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/22/1874
9. AGE (In years last birthday) 84	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Coal Mining	11. KIND OF BUSINESS OR INDUSTRY & Store Clerk	12. BIRTHPLACE (State or foreign country) Frostburg, Maryland
13. FATHER'S NAME William S. Hoblitzell	14. MOTHER'S MAIDEN NAME Margaret P. Shearer		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)	16. SOCIAL SECURITY NO. None	17. INFORMANT P.O.Box 599, Allegany County Infirmary Records	Address Cumberland, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Chronic Myocardial Degeneration (c) DUE TO Cerebral Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH Second
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchial asthma			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 5/20/57 , 19, to 3/22/59 , 19, that I last saw the deceased alive on 3/21/59 , 19, and that death occurred at 12:10P M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>James E. McLean</i> M.D. ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 3/23/59			
PHYSICIAN'S NAME (Type) Dr. James E. McLean		Cumberland, Maryland	
22o. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-24-59	22c. NAME OF CEMETERY OR CREMATORIUM F'bg. Memorial Park	22d. LOCATION (City, town, or county) (State) Frostburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst, Frostburg, Md.		ADDRESS	24a. REC'D BY REGISTRAR DATE MAR 26 '59
			24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thane</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 could be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

STATE OF ILLINOIS - DEPARTMENT OF STATE

CERTIFICATE OF DEATH

NAME OF DECEASED: John J. Murphy
ADDRESS: 100 W. Madison St., Chicago, Ill.
AGE: 60 years
SEX: Male
MATERIAL TESTED: Blood

TEST NUMBER: 18058 DATE: July 20, 1933
TESTED BY: John J. Murphy SIGNED: John J. Murphy

RESULTS: Found no evidence of alcohol or drugs in blood.
Tested negative for morphine.

REMARKS: Specimen obtained from deceased man.
Specimen taken from deceased man.

TEST NUMBER: 18059 DATE: July 20, 1933
TESTED BY: John J. Murphy SIGNED: John J. Murphy

RESULTS: Found no evidence of alcohol or drugs in blood.
Tested negative for morphine.

REMARKS: Specimen obtained from deceased man.
Specimen taken from deceased man.

TEST NUMBER: 18060 DATE: July 20, 1933
TESTED BY: John J. Murphy SIGNED: John J. Murphy

RESULTS: Found no evidence of alcohol or drugs in blood.
Tested negative for morphine.

REMARKS: Specimen obtained from deceased man.
Specimen taken from deceased man.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2532

CERTIFICATE OF DEATH

02535

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. LENGTH OF STAY IN 1b RURAL and give nearest town Cumberland,				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 119 Polk St.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Bernadette Veronica Hoenicka		First Bernadette	Middle Veronica			
4. DATE OF DEATH March 13, 1959		Last Hoenicka	Month Day Year			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 25, 1889			
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Cumberland, Md.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James McKenzie				
14. MOTHER'S MAIDEN NAME Sarah McKenzie		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,				
16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Reid C. Hoenicka				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		Coronary Occlusion				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		INTERVAL BETWEEN ONSET AND DEATH				
DUE TO Arteriosclerosis						
DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Mar. 13, 1959	(County) 450 N. Centre St.	(State) Cumberland, Md.
21. I certify that I attended the deceased from Sec. , 19 58 , to Mar. 13, 1959 , that I last saw the deceased alive on Mar. 13, 1959 , and that death occurred at 9:40 P.M. from the causes and on the date stated above.						
ACTUAL SIGNATURE Leo H. Ley Jr.		ADDRESS (Street, city or town, state) 450 N. Centre St.		DATE SIGNED 3/13/59		
PHYSICIAN'S NAME (Type) Leo H. Ley Jr.		Cumberland, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/16/59	22c. NAME OF CEMETERY OR CREMATORIUM St. Patrick's Cem.	22d. LOCATION (City, town, or county) Cumberland, Maryland	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	24a. REC'D BY REGISTRAR Arthur S. Kraus	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	DATE MAR 17 '59	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

卷之三

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2533

CERTIFICATE OF DEATH

02536

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		d. STREET ADDRESS Hanekamp		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Edith	Middle 	Last Holder	4. DATE OF DEATH	Month March	Day 31	Year 19 59
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Sept 27, 1889	9. AGE (In years lost birthday) 69 yrs.	IF UNDER 1 YEAR Months 	IF UNDER 24 HRS. Days 	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Office Work		11. BIRTHPLACE (State or foreign country) Lonaconing, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert Holder				14. MOTHER'S MAIDEN NAME Ann Bowden			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Ella Braznelle Lonaconing, Md. "Sister"		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO Carcinoma of the lung, alveolar type DUE TO DUE TO 							
INTERVAL BETWEEN ONSET AND DEATH 6 mo.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 	
21. I certify that I attended the deceased from 3/1/59 , 19 59 , to 3/31 , 19 59 , that I last saw the deceased alive on 3/31 , 19 59 , and that death occurred at 2 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 							
DATE SIGNED 							
ACTUAL SIGNATURE George Eichhorn							
PHYSICIAN'S NAME (Type) George Eichhorn							
22a. BURIAL, CREMATION, BURIAL (Specify) Burial		22b. DATE THEREOF 4/3/59		22c. NAME OF CEMETERY OR CREMATORIAL Oak Hill Cemetery		22d. LOCATION (City, town, or county) (State) Lonaconing, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn				ADDRESS Lonaconing, Md.		24a. REC'D BY REGISTRAR DATE APR 6 '59	
						24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WISCONSIN STATE DEPARTMENT OF HEALTH - JOURNAL NO. 18

CERTIFICATE OF DEATH

NAME OF DECEASED	AGE	SEX	DEATH DATE	TIME	CAUSE OF DEATH	DEATH CERTIFIED BY
JOHN D. HANSON	60	M	APRIL 10, 1918	10:00 A.M.	CHLOROFORM	DR. WALTER L. HANSON
ADDRESS OF DECEASED						
101 E. 10th Street, Milwaukee, Wisconsin						
MATERIAL TESTED						
CHLOROFORM						
TESTED BY						
DR. WALTER L. HANSON						
APPROVED						
DR. WALTER L. HANSON						
APRIL 10, 1918						

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2534

CERTIFICATE OF DEATH

Reg. Dist. No.

02537

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 21 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL AND WARWICK AVENUES		d. STREET ADDRESS 512 HILL STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) WILLIAM SCOTT		First WILLIAM	Middle SCOTT	Last HOLLINGSWORTH	4. DATE OF DEATH MARCH 9 1959	Month MARCH	Day 9	Year 1959
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH JUNE 1889	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Bell Hop		10b. KIND OF BUSINESS OR INDUSTRY Windsor Hotel		11. BIRTHPLACE (State or foreign country) MOOREFIELD, W.VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME WILLIAM HOLLINGSWORTH			14. MOTHER'S MAIDEN NAME BERTHA WILLIS			Address CUMBERLAND, MARYLAND		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Arteriosclerosis (c)								
INTERVAL BETWEEN ONSET AND DEATH 12 hrs								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic Jaundice - both feet.								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part II or Part III of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 2-16 , 19 58 , to 3-9 , 19 59 , that I last saw the deceased alive on 3-9 , 19 59 , and that death occurred at 10:00P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 445 N Cedar St DATE SIGNED 3-16-59								
ACTUAL SIGNATURE <i>William R. James</i>		M.D.						
PHYSICIAN'S NAME (Type) William James		Cumberland, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/12/59		22c. NAME OF CEMETERY OR CREMATORIUM Woodlawn Bur. Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				ADDRESS		24a. REC'D BY REGISTRAR DATE MAR 13 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hafer</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper page 1 and 2 and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

113

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 3 Film G239 3-16-59 et

2535

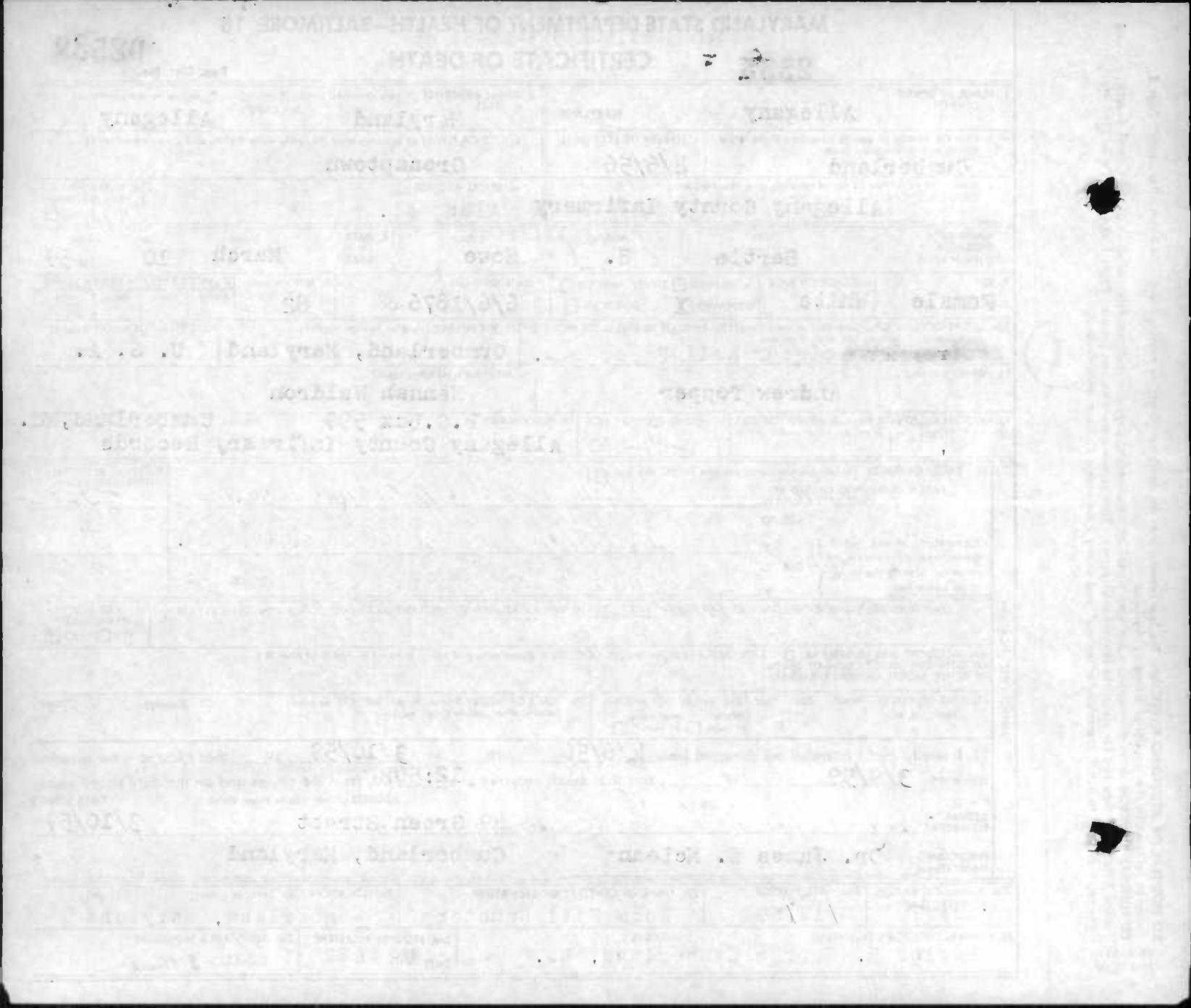
CERTIFICATE OF DEATH

02538

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the registrar's office, to a burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		b. COUNTY Allegany	
c. LENGTH OF STAY IN lb 4/6/56		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cresaptown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		d. STREET ADDRESS Along Rt. # 220	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (First and Middle name) Bertie H. Willison		4. DATE OF DEATH Month March Day 10 Year 1959	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 6/6/1876	
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) yrs. 82	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Proprietor		10b. KIND OF BUSINESS OR INDUSTRY Wall Paper Bus.	
11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Andrew Topper		14. MOTHER'S MAIDEN NAME Hannah Waldron	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. 705-09-3513	
17. INFORMANT P.O. Box 599 Address Cumberland, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 72 hrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Rh. Hemiplegia	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/6/56 , 19, to 3/10/59 , 19, that I last saw the deceased alive on 3/9/59 , 19, and that death occurred at 12:50 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE James E. McLean		ADDRESS (Street, city or town, state) 49 Green Street	
PHYSICIAN'S NAME (Type) Dr. James E. McLean		DATE SIGNED 3/10/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/12/59	
22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Ms.	
24a. REC'D BY REGISTRAR DATE MAR 16 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2560

CERTIFICATE OF DEATH

02539

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		d. STREET ADDRESS High Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) PHOEBE ELLEN HUMPHREY		First	Middle	Last	4. DATE OF DEATH March 18th. 1959	Month	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH July 27, 1879	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Rawlings, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Sheppard		14. MOTHER'S MAIDEN NAME Margaret Carter						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Sarah Harris, Frostburg, MD.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b)		DAUGHTER Myocardial Ischemia + failure		INTERVAL BETWEEN ONSET AND DEATH 2 days		
		DUE TO (c)		Arteriosclerotic Cardio-vascular disease		years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Lonaconing	(County)	(State)
21. I certify that I attended the deceased from July 18, 1956 , to March 18, 1959 , that I last saw the deceased alive on March 18, 1959 , and that death occurred at 8 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Lonaconing, MD.								
ACTUAL SIGNATURE <i>Leslie R. Miles</i>	DATE SIGNED 3-20-59							
PHYSICIAN'S NAME (Type) LESLIE R. MILES JR	M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/21/1959	22c. NAME OF CEMETERY OR CREMATORIUM Oak Hill Cemetery		22d. LOCATION (City, town, or county) Lonaconing, MD.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHORN		ADDRESS LONACONING, MD.		24a. REC'D BY REGISTRAR DATE MAR 23 '59	24b. REGISTRAR'S SIGNATURE Albert J. ...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2536 CERTIFICATE OF DEATH

Reg. Dist. No. **112540**

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 3/10/59		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Spring Gap			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		e. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Stella		First A.	Middle Irons	4. DATE OF DEATH March 12, - 1959	Month March	Day 12	Year 1959
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 11, 1897	9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY Baltimore U.S.A.	
13. FATHER'S NAME Border Erison				14. MOTHER'S MAIDEN NAME ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Husband Earl Irons, SpringGap Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Theresa INTERVAL BETWEEN ONSET AND DEATH 70 days 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocarditis & Decompensation vyr (c) Arteriosclerous 5 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1956 to Mar 12, 1959 , that I last saw the deceased alive on Mar. 12, 1959 , and that death occurred at M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 236 Virginia Avenue, Cumberland, Allegany County, Maryland DATE SIGNED 3/14/59							
ACTUAL SIGNATURE Clay E. Durrett		PHYSICIAN'S NAME (Type) Clay E. Durrett M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/15/59		22c. NAME OF CEMETERY OR CREMATORIUM Davis Mem. Meth. Cemetery		22d. LOCATION (City, town, or county) (State) Allegany County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		ADDRESS 24a. REC'D BY REGISTRAR MAR 19 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2581

Reg. Dist. No.

02541

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN lb 16 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miner's Hospital		d. STREET ADDRESS 302 Welsh Hill		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First William	Middle A.	Last Kear	4. DATE OF DEATH Month 3	Month 14	Day 19	Year 59
5. SEX Male	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 8/5/1880	9. AGE (In years lost birthday) yrs. 78	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Mail Carrier		10b. KIND OF BUSINESS OR INDUSTRY U.S. Post Office		11. BIRTHPLACE (State or foreign country) Frostburg, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Kear				14. MOTHER'S MAIDEN NAME Cinderella Ferry			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. WM. A. Kear, 302 Welsh Hill.		Address Frostburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) myocardial insufficiency							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Frostburg		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 4 , 1958 to Mar 14 , 1959, that I last saw the deceased alive on Mar 14 , 1959, and that death occurred at 9:45 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE WOMC Lane		ADDRESS (Street, city or town, state) Frostburg DATE SIGNED Mar 16 1959					
PHYSICIAN'S NAME (Type) WOMC Lane MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-17-59		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Frostburg Memorial Park, Frostburg		22d. LOCATION (City, town, or county) (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hafer Funeral Home		ADDRESS 23 E. Main, Frostburg, Md.		24a. REC'D BY REGISTRAR DATE MAR 19 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH - DIVISION OF
CERTIFICATE OF DEATH

Death certificate

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2537

CERTIFICATE OF DEATH

02542

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. Winchester Rd. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 2 mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		d. STREET ADDRESS Rt. 5, Winchester Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Harry	Middle William	Last Kelly	4. DATE OF DEATH March 22, 1959	Month Day Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 13, 1880	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Janitor		10b. KIND OF BUSINESS OR INDUSTRY Apt. Houses		11. BIRTHPLACE (State or foreign country) PA. Somerset County	
13. FATHER'S NAME Henry Kelly		14. MOTHER'S MAIDEN NAME Anna Emerick		12. CITIZEN OF WHAT COUNTRY U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. 220-10-7987		17. INFORMANT Mrs. Alberta Lease, Rt # 5 Winchester Rd.	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 33IX DUE TO opgletin stroke				INTERVAL BETWEEN ONSET AND DEATH 2 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO cerebral arteriosclerosis				2 years	
(c) generalized arteriosclerosis				2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-2 , 19 58 , to 3-22- , 19 59 , that I last saw the deceased alive on 3-22- , 19 59 , and that death occurred at 9 30 M, from the causes and on the date stated above. ACTUAL SIGNATURE Chas				ADDRESS (Street, city or town, state) 57 Green St. DATE SIGNED	
PHYSICIAN'S NAME (Type) LEHIS BRINGS MD				Cumberland Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 25, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Lybarger Cemetery	
22d. LOCATION (City, town, or county) Madley, Pa.				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE MAR 26 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Thrus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAXWELL STATE PENITENTIARY OF HENRY - BUREAU OF DEATH

CERTIFICATE OF DEATH

1

**FOR STATE
HEALTH DEPT.**

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the State Health Department.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Health Department, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

**VS. A15ME
BM 2/57**

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02543

Reg. Dist. No.

2538

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY Allegany		a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb ✓	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8105 Frederick Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) L Leroy Emerson Kimes		4. DATE OF DEATH Month March Day 15 Year 1959	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH April 15, 1883	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Druggist		10b. KIND OF BUSINESS OR INDUSTRY Druggist	
11. BIRTHPLACE (State or foreign country) Keyser W.Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Kimes		14. MOTHER'S MAIDEN NAME Anna R. Mohler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 220-38-0086	
17. INFORMANT		Address Medical Examiner, Cumb. Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		Coronary occlusion Sudden	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b)		Coronary Sclerosis —	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Cumberland (County) Maryland (State) MD	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic		DATE SIGNED March 15, 1959	
EXAMINER'S NAME (Type) Benedict Skitarelic, MD		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 18, 1959	
22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town, or county) Cumberland, Maryland (State) MD	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc. Cumb. Md		24a. REC'D BY REGISTRAR MAR 20 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Thorne	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2539

CERTIFICATE OF DEATH

02544

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE PENNA.		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 21 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - WELLENSBURG		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First JOHN	Middle RANDOLPH	Last KIRBY	4. DATE OF DEATH	Month MARCH	Day 10,	Year 19 59	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH DEC. 29	9. AGE (In years lost birthday) yrs. 37	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SCHOOL TEACHER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY		
13. FATHER'S NAME GEORGE A. KIRBY (DECEASED)			14. MOTHER'S MAIDEN NAME ANNA E. LEWIS			Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. II		17. INFORMANT		PATIENTS CHART		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
INTERVAL BETWEEN ONSET AND DEATH 3 weeks								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 3-16-1959 to 3-10-1959 , that I last saw the deceased alive on 3-9-1959 , and that death occurred at 3:25A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 16 Greene St Cumberland MD 3-18-59								
ACTUAL SIGNATURE James T. Johnson, Jr., M.D.		DATE SIGNED 3-18-59						
PHYSICIAN'S NAME (Type) JAMES T. JOHNSON, JR., M.D.		16 GREENE ST., CUMBERLAND, MD.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-14-59	22c. NAME OF CEMETERY OR CREMATORIUM Cook Cemetery	22d. LOCATION (City, town, or county) Wellersburg, Pa.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		ADDRESS	24a. REC'D BY REGISTRAR MAR 16 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF HAWAII - DIVISION OF HUMAN RESOURCES
CERTIFICATE OF DEATH

() NO. 2015

02545

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File Pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. LENGTH OF STAY IN lb 72 Cumberland,	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary		d. STREET ADDRESS 3 Decatur St.,	
3. NAME OF DECEASED (Type or print) WILLIAM Evert KNIPPENBERG		First WILLIAM	Middle Evert
3. NAME OF DECEASED (Type or print) WILLIAM Evert KNIPPENBERG		Last KNIPPENBERG	4. DATE OF DEATH March 4 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 1, 1876
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 82 yrs.	10. IF UNDER 1 YEAR Months 0 Dots 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Maintenance man		10b. KIND OF BUSINESS OR INDUSTRY Kelly Tire Co.	11. BIRTHPLACE (State or foreign country) Cumberland, Md.
13. FATHER'S NAME Henry Knippenberg		14. MOTHER'S MAIDEN NAME Luetetia Logsdon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-10-1506	17. INFORMANT Mrs. Percival Twigg
		Address Cumberland, Md. 1001 Church St.,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebellar Necrosis INTERVAL BETWEEN ONSET AND DEATH 332 X Years DUE TO Conditions, if any, which gave rise to immediate cause (b) Cerebral Arteriosclerosis, Marked Years (c) DUE TO (c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? Fractured Ribs YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. X		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell At County Home, Cumberland, Md.	
20c. TIME OF INJURY Month, Day, Year Hour 5 P.M. March 1 1959		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) County home
		20f. (City or town) Cumberland, Alleg. Md.	(County) Cumberland (State) Alleg. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		DATE SIGNED March 4, 1959	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/7/59	22c. NAME OF CEMETERY OR CREMATORIUM Greenmount Cemetery
		22d. LOCATION (City, town, or county) Cumberland, Md.	(State)
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	24a. REC'D BY REGISTRAR MAR 9 '59
			24b. REGISTRAR'S SIGNATURE Arthur S. Krause

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02546

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,		c. LENGTH OF STAY IN lb 9 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND,				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL, MEMORIAL AVE.		d. STREET ADDRESS 119 S.ALLEGANY ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First HAZEL	Middle ALCINDIA	Last LEMON	4. DATE OF DEATH	Month MARCH	Day 20	Year 19 59
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11/14/ 1900	9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months 58	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Confectionary		11. BIRTHPLACE (State or foreign country) TERRA ALTA,W.VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JOHN ELSEY		14. MOTHER'S MAIDEN NAME MAXIE FORMAN						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 234-03-0635		17. INFORMANT		Address MEMORIAL HOSPITAL, CUMBERLAND, MD.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
				INTERVAL BETWEEN ONSET AND DEATH 16 mos.				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 62 Greene St.		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 11 - 21 , 19 58 , to 3-21 , 19 59 , that I last saw the deceased alive on 3 - 21 , 19 59 , and that death occurred at 9:20AM , from the causes and on the date stated above. ACTUAL SIGNATURE Ralph W. Ballin, M.D. ADDRESS (Street, city or town, state) 62 Greene St. DATE SIGNED 3-22-59								
PHYSICIAN'S NAME (Type) Ralph W. Ballin, M.D.		Cumberland, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 23, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Sunset Memorial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE MAR 26 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WATERBURY - STATE OF CONNECTICUT
CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2542

CERTIFICATE OF DEATH

Reg. Dist. No.

02547

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA		b. COUNTY MINERAL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 10 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIDGELEY		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL		d. STREET ADDRESS RFD #1					

3. NAME OF DECEASED (Type or print)	First CHARLES	Middle J.	Last MACKERT	4. DATE OF DEATH	Month MARCH	Day 15	Year 19 59
---	-------------------------	---------------------	------------------------	------------------------	-----------------------	------------------	----------------------

5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 5-16-1900	9. AGE (In years less birthday) 58	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Hours 0
-----------------------	----------------------------------	---	--------------------------------------	---	---------------------------------------	---------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Baker	10b. KIND OF BUSINESS OR INDUSTRY Wholesale Bakery	11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	12. CITIZEN OF WHAT COUNTRY? McKeesport U.S.A.
---	--	--	--

13. FATHER'S NAME CHARLES J. MACKERT (Deceased)	14. MOTHER'S MAIDEN NAME LUCY SCHELLHOUSE (Deceased)
---	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 214-05-6878	17. INFORMANT CHART	Address
--	---	-------------------------------	---------

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 490 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gastric Ulceritis DUE TO (c) Gastric Ulceritis	INTERVAL BETWEEN ONSET AND DEATH 11 days
--	--

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
--	--	---

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
--	--	--	--

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
--	---	--	--

21. I certify that I attended the deceased from 3-5-1959 to 3-15-1959 , and that I last saw the deceased alive on 3-14-1959 , and that death occurred at 3-15-1959 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE J. T. Johnson, M.D.	ADDRESS (Street, city or town, state) 16 Green Street, Cumberland, Md.	DATE SIGNED 3-16-59
--	--	-------------------------------

PHYSICIAN'S NAME (Type) J. T. JOHNSON, M.D.	22c. NAME OF CEMETERY OR CREMATORIUM St. Peter & Paul Cem	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
---	---	--

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-19-59
--	-------------------------------------

23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli	ADDRESS Cumberland, Md.
---	-----------------------------------

24a. REC'D BY REGISTRAR DATE MAR 19 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Trahan
--	---

10. **CHARTER**—**STANDARD CONTRACTS** STATE **GENERAL**

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2543

CERTIFICATE OF DEATH

Reg. Dist. No.

02548

1		TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.	
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.		I	
1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 15 MINS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL WARWICK AND MEMORIAL AVENUES		e. STREET ADDRESS 137 REYNOLDS STREET	
3. NAME OF DECEASED (Type or print) First BABY Middle GIRL Last MATHEWS		4. DATE OF DEATH Month MARCH Day 15 Year 1959	
5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH MARCH 15, 1959	
9. AGE (In years lost birthday) yrs. 15		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES D. MATHEWS		14. MOTHER'S MAIDEN NAME RUTH LAVERNE GEORGE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Address MEMORIAL HOSPITAL CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 770.0 DUE TO <i>Hydrogen</i>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>15 March 1959</u> to <u>19</u> , that I last saw the deceased alive on <u>15 March 1959</u> , and that death occurred at <u>6:00 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>Donald L. Ransom</u> M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>3-17-59</u>	
22c. NAME OF CEMETERY OR CREMATORIAL <u>Memorial Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Memorial Hospital</u> <u>see L. Mathews</u>		24a. REC'D BY REGISTRAR ADDRESS <u>Memorial Avenue</u> DATE <u>MAR 18 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hause</u>	

22631
STATE OF CALIFORNIA - DIVISION OF HIGHWAYS - SAN FRANCISCO

CERTIFICATE OF PLAN

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

1952

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2583

CERTIFICATE OF DEATH

Reg. Dist. No.

02549

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Cumberland		c. LENGTH OF STAY IN 1b 83 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Valley Road		e. STREET ADDRESS 1 Valley Road	
3. NAME OF DECEASED (Type or print) AUGUSTINE		First M.	Middle McELFISH
4. DATE OF DEATH March 31, 1959	Month March	Day 31	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH July 13, 1872
8. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) 86 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Flintstone, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John McElfish		14. MOTHER'S MAIDEN NAME Isabelle Duncan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Melissa McElfish		Address Valley Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Congestive Heart Failure		INTERVAL BETWEEN ONSET AND DEATH 2 wks	
(b) DUE TO Arterio sclerotic Heart Disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
(c)		?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral vascular accident - & hemiplegia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b) White Not while at work	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. , 19 59 , to Mar. 31 , 19 59 , that I last saw the deceased alive on Mar. 27 , 19 59 , and that death occurred at 1100 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 440 W. Locust St. DATE SIGNED 4-2-59			
ACTUAL SIGNATURE William R. James		M.D.	
PHYSICIAN'S NAME (Type) William R. James		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/3/1959	
22c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park		22d. LOCATION (City, town, or county) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Knight		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR Arthur S. Evans		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

NEW YORK STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

CERTIFICATE OF DEATH

5-19-19

MAY 19, 1918

NAME

ADDRESS

CITY

STATE

ZIP

PHONE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG240 3-19-59 et

2544

CERTIFICATE OF DEATH

02550

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland	b. COUNTY Allegany					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	d. STREET ADDRESS 226 Elder St					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 204 Elder Street	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Joseph Milton	First Joseph	Middle Milton	Last Nealis	4. DATE OF DEATH Month March	Day 13	Year 1959		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH July 24, 1867	9. AGE (In years from birthday) yrs. 91	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer Labor	10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (State or foreign country) Peoria, Ill	12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME John Nealis	14. MOTHER'S MAIDEN NAME Diana McBride							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Harry Nealis 204 Elder St Cumberland	Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Pancreas					3 mo.			
DUE TO 157X								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease (c) Abdominal Carcinomatosis								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Advanced age								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none							
20c. TIME OF INJURY Month, Day, Year Hour o. m. none 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from June 11, 1956 , to March 13, 1959 , that I last saw the deceased alive on March 13, 1959 , and that death occurred at 5:10 A.M. from the causes and on the date stated above.					ADDRESS (Street, city or town, state) 140 Bedford Street			
ACTUAL SIGNATURE <i>James P. Hallinan M.D.</i>	M.D.				DATE SIGNED 3/11/59			
PHYSICIAN'S NAME (Type) James P. Hallinan M. D.	Cumberland, Maryland.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-16-59	22c. NAME OF CEMETERY OR CREMATORIUM Fort Ashby Cem.	22d. LOCATION (City, town, or county) (State) Fort Ashby, W. Va.					
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli	ADDRESS Cumberland, Md.	24a. REC'D BY REGISTRAR DATE MAR 17 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Knapp					

DEPARTMENT OF HEALTH-EDUCATION-CULTURE

CERTIFICATE OF DEATH

DEATH CERTIFICATE
NAME: JOHN D. SMITH
ADDRESS: 123 FAIRFIELD DR.
CITY: NEW YORK
STATE: NEW YORK
ZIP: 100-0000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2582

CERTIFICATE OF DEATH

Reg. Dist. No.

02551

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Allegany			MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland			b. COUNTY Allegany						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg			c. LENGTH OF STAY IN 1b Lifetime			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 84 E. Main St.			d. STREET ADDRESS 84 E. Main Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		First Alvin	Middle C.	Last Nickel	4. DATE OF DEATH March 12th, 1959	Month March	Day 12th	Year 1959	IF UNDER 1 YEAR Months 78	IF UNDER 24 HRS. Days 78	Hours 0	Min. 0			
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Dec. 12th, 1880	9. AGE (In years last birthday) 78 yrs.										
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-employed Uph.			10b. KIND OF BUSINESS OR INDUSTRY Upholsterer			11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA						
13. FATHER'S NAME Conrad Nickel			14. MOTHER'S MAIDEN NAME Margaret Hartman			INFORMANT Florian Nickel, 157 First St., F'bg.Md.			Address						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO. Spanish-Amer.			INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 420.0			DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the under- lying cause lost.			Coronary Heart Disease 2 hr									
DUE TO (b)			DUE TO arteriosclerotic Heart Disease			3 yrs									
DUE TO (c)															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)												
20c. TIME OF INJURY Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) "			20f. (City or town) "		(County) "	(State) "			
21. I certify that I attended the deceased from alive on March 12, 1959 , and that death occurred at 4:00 P.M. , from the causes and on the date stated above.									ADDRESS (Street, city or town, state) "			DATE SIGNED 3/13/59			
ACTUAL SIGNATURE John B. Davis, M.D.			22. BURIAL, CREMATION, REMOVAL (Specify) Cremation						22b. DATE THEREOF 3-15-59			22c. NAME OF CEMETERY OR CREMATORIUM Homewood Cemetery		22d. LOCATION (City, town, or county) Pittsburgh, Pa.	
PHYSICIAN'S NAME (Type) John B. Davis,			22b. DATE THEREOF 3-15-59						22c. NAME OF CEMETERY OR CREMATORIUM Homewood Cemetery			22d. LOCATION (City, town, or county) Pittsburgh, Pa.			
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst, Frostburg, Md.			22d. LOCATION (City, town, or county) Pittsburgh, Pa.						24a. REC'D BY REGISTRAR MAR 17 '59			24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

HAZO TO HADWILL

5022

1000 ft. 1A

bivalve

valve 1A

gastropod

ammonite

predator

testic nish. 448

18 May 1948

1955

decalc

leach

niva

obs. last sec. 1000 ft.

predator

all

bivalve

conchidell

sh. bivalve 1A

small fragments

testic bivalve

hadw. 10 July 1955. Testic nish. 1

predator

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2545

CERTIFICATE OF DEATH

02552

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		d. STREET ADDRESS 1708 Frederick St.,					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 708 Frederick St.,				d. STREET ADDRESS 1708 Frederick St.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Cecil James Northcraft		First	Middle	Last	4. DATE OF DEATH March 26, 1959	Month	Day	Year			
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 18, 1912		9. AGE (In years last birthday) 46 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10b. KIND OF BUSINESS OR INDUSTRY Clothing Store		11. BIRTHPLACE (State or foreign country) Accident, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME Frank J. Northcraft				14. MOTHER'S MAIDEN NAME Elizabeth Hoffman							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. 217-10-7425		17. INFORMANT Mrs. Lillian J. Northcraft		Address Cumberland, Md 708 Frederick St					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0		DUE TO Dental caries on lower teeth		INTERVAL BETWEEN ONSET AND DEATH 1/2 hour							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO Diabetes with heart disease		2 months							
(c)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 2-3-1959 to 3-26-1959 , that I last saw the deceased alive on 3-20-1959 , and that death occurred at 11:30 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE L. Brings		M.D. 57 Greene St.		ADDRESS (Street, city or town, state) Cumberland, Md.					DATE SIGNED		
PHYSICIAN'S NAME (Type) Lewis Brings M.D.											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/29/59		22c. NAME OF CEMETERY OR CREMATORIUM Lutheran Cemetery		22d. LOCATION (City, town, or county) Accident, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Maryland		24a. REG'D BY REGISTRAR MAR 30 59		24b. REGISTRAR'S SIGNATURE Arthur S. Tracy			DATE		

DEPARTMENT OF HEDWIG - GARDENING

CERTIFICATE OF DESIGN

RECEIVED
MAY 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG239 3-12-59 et

02558

2546

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland,		d. STREET ADDRESS 1 Cresap Drive-Bowling Green							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Edith		First	Middle E.	Last Oats	4. DATE OF DEATH March 3 1959	Month March	Day 3	Year 1959					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3/9/1880	9. AGE (In years lost birthday) 79 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) W. VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George H. Oates				14. MOTHER'S MAIDEN NAME Mary Blacjburn									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None		17. INFORMANT Brother - Marshall Oats, Baltimore, Md.		Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 144X DUE TO Carcinoma of the mouth (squamous cell) INTERVAL BETWEEN ONSET AND DEATH 3 days													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) melanotic carcinoma fracture DUE TO 1 year													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 57 Green St		(County) Cumberland	(State) Md.				
21. I certify that I attended the deceased from 4-3- , 19 56 , to 3-5 , 19 57 , that I last saw the deceased alive on 3-5 , 19 57 , and that death occurred at 9:00 P.M. from the causes and on the date stated above.													
ACTUAL SIGNATURE L. Brins		M.D.		ADDRESS (Street, city or town, state) 57 Green St					DATE SIGNED				
PHYSICIAN'S NAME (Type) Byron Kight		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 3/8/1959							22c. NAME OF CEMETERY OR CREMATORIUM Hill Crest Cem.		22d. LOCATION (City, town, or county) Cumberland, Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR MAR 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Krause							

MANUFACTURE OF HAT - GAITHERSBURG - MARYLAND

CERTIFICATE OF SEALEY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9, Film G240, 3/23/59 fcy

2547

02554

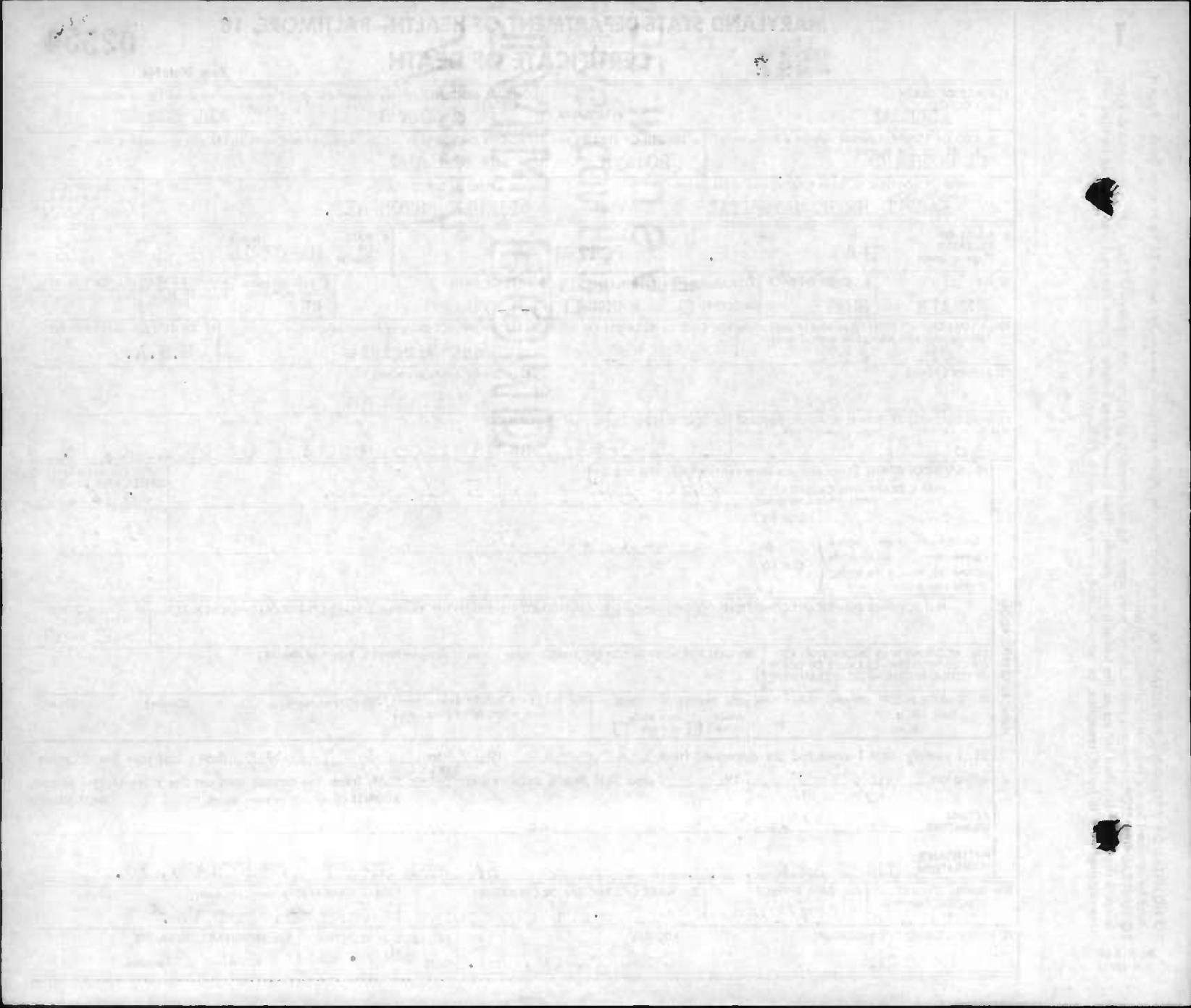
CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND		b. COUNTY ALL EGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 20days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL				d. STREET ADDRESS 521 HENDERSON AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) INA		First K.	Middle PORTER	Lost	4. DATE OF DEATH MARCH 14	Month MARCH	Day 14	Year 1959
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-1-03		9. AGE (In years lost birthday) 556 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurses Aide		10b. KIND OF BUSINESS OR INDUSTRY Hospital		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME James Keesee				14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218 24 8654		17. INFORMANT Chart Harmon Porter		Address Cumberland, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Congestive heart failure cirrhosis of the liver								
INTERVAL BETWEEN ONSET AND DEATH 6 days 2 gms								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 2-1 , 19 59 to 3-14 , 19 59 , that I last saw the deceased alive on 3-14-59 , 19 59 , and that death occurred at 10:35A.M. from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>R. Brings</i>		ADDRESS (Street, city or town, state) 57 GREEN STREET CUMBERLAND, Md.						
DATE SIGNED								
PHYSICIAN'S NAME (Type) LENTIS BRINGS, M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/17/1959		22c. NAME OF CEMETERY OR CREMATORIUM Hill Crest Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE MAR 19 59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2583

CERTIFICATE OF DEATH

02555

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 15 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		d. STREET ADDRESS 115 Hill Street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 115 Hill Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Sarah		First	Middle	Last	4. DATE OF DEATH March 17th, 1959	Month	Day	Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Jan. 6th, 1930	9. AGE (In years lost birthday) 29 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own housework		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Herbert Meyers		14. MOTHER'S MAIDEN NAME Grace Rodda						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT	Address Donald Pressman, 115 Hill St., F'bg., Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 481X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) influenza (c)		DUE TO		acute Cardiac Dilatation		INTERVAL BETWEEN ONSET AND DEATH sudden		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						3 Days		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Doy	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Mar 13, 1959	(County)	(State)
21. I certify that I attended the deceased from Mar 13, 1959 to Mar 17, 1959 , that I last saw the deceased alive on Mar 16, 1959 , and that death occurred at 2:07 A.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED		
ACTUAL SIGNATURE W. O. McLane		M.D. W. O. McLane		M.D. " " "		Mar 18/1959		
PHYSICIAN'S NAME (Type) W. O. McLane,		M.D. " " "						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-19-59		22c. NAME OF CEMETERY OR CREMATORIUM Eckhart Cemetery		22d. LOCATION (City, town, or county) Eckhart,		(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst, Frostburg, Md.		ADDRESS		24a. REC'D BY REGISTRAR Mar 20 '59		24b. REGISTRAR'S SIGNATURE Charles L. Thomas		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be referred to by the hospital or attending physician and completely filled in by the funeral director.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2548

CERTIFICATE OF DEATH

12556

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 5yr.6mo.16das.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sylvan Retreat		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Cumberland	
3. NAME OF DECEASED (Type or print) First Emma Middle Brode Last Rice		4. DATE OF DEATH Month March Day 30 Year 1959	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH May 7, 1878	
9. AGE (In years lost birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Dows Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel Brode		14. MOTHER'S MAIDEN NAME Rosena Lemmert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Sylvan Retreat Records, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420 Coronary Sclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) 437 Myocardial Degeneration DUE TO (c) 456 General arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 304 Severe psychosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____ to _____, that I last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above. ACTUAL SIGNATURE James E. McLean, M.D.		ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED	
PHYSICIAN'S NAME (Type) James E. McLean, M.D.		49 Greene St., Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/1/1959	
22c. NAME OF CEMETERY OR CREMATORIUM Mt. Pleasant Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR APR 1 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Frana	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 may be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
1SM 10/57

CEREMONIALS OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2543

CERTIFICATE OF DEATH

Reg. Dist. No.

102557

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 1 hour		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X La Vale			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		d. STREET ADDRESS 441 National Highway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First TEXI	Middle RITCHIE	Last	4. DATE OF DEATH	Month March	Day 5	Year 1959
5. SEX	6. COLOR OR RACE Female White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH May 22, 1886	9. AGE (in years last birthday) 72	IF UNDER 1 YEAR Months 72	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Harman, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Cooper		14. MOTHER'S MAIDEN NAME Elmira McDonald					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT John W. Ritchie, M.		Address La Vale, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Ento coronary occlusion						INTERVAL BETWEEN ONSET AND DEATH 4 hours	
(b) DUE TO arterioscleris heart disease						6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 10300	20f. (City or town) Harman, W. Va.	(County)	(State)
21. I certify that I attended the deceased from 3-4 , 19 57 , to 3-5 , 19 57 , that I last saw the deceased alive on 3-5 , 19 57 , and that death occurred at 10300 M, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 57 Green St.		DATE SIGNED Cumberland, Md.	
ACTUAL SIGNATURE H. R. Kight			M.D.				
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/8/1959	22c. NAME OF CEMETERY OR CREMATORIAL Cooper Cemetery	22d. LOCATION (City, town, or county) Harman, W. Va.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE William H. Kight,		ADDRESS Cumberland, Md.	24a. REC'D BY REGISTRAR MAR 9 '59		24b. REGISTRAR'S SIGNATURE Wm. S. French		

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE CITY

CERTIFICATE OF DEATH

10250

Date of Birth

Name of Deceased

Reporting Doctor

Cause of Death

Place of Death

Time of Death

Date of Death

Age at Death

Sex

Race

Color

Marital Status

Occupation

Employment

Address

Employer

City

Employer's Address

State

Employer's Phone Number

Phone Number

Employer's Name

Name

Employer's Address

Address

Employer's Phone Number

Phone Number

Employer's Name

Name

Employer's Address

Address

Employer's Phone Number

Phone Number

Employer's Name

Name

Employer's Address

Address

Employer's Phone Number

Phone Number

Employer's Name

Name

Employer's Address

Address

Employer's Phone Number

Phone Number

Employer's Name

Name

Employer's Address

Address

Employer's Phone Number

Phone Number

Employer's Name

Name

Employer's Address

Address

Employer's Phone Number

Phone Number

Employer's Name

Name

Employer's Address

Address

Employer's Phone Number

Phone Number

Employer's Name

Name

Employer's Address

Address

Employer's Phone Number

Phone Number

Employer's Name

Name

Employer's Address

Address

Employer's Phone Number

Phone Number

Employer's Name

Name

Employer's Address

Address

Employer's Phone Number

Phone Number

Employer's Name

Name

Employer's Address

Address

Employer's Phone Number

Phone Number

Employer's Name

Name

Employer's Address

Address

Employer's Phone Number

Phone Number

FREDERICA

BUREAU OF RECORDS AND REGISTRATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 Film 241-4-6-59 ams

2550

CERTIFICATE OF DEATH

Reg. Dist. N 02552

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X CUMBERLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL AND WARWICK AVENUES		d. STREET ADDRESS RT. #3, BEDFORD ROAD	
3. NAME OF DECEASED (Type or print) First LINDA Middle SUE Last ROYCE		4. DATE OF DEATH Month MARCH Day 26 Year 1959	
5. SEX FEMALE COLOR OR RACE WHITE		6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 7. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
		8. DATE OF BIRTH JULY 12	
9. AGE (In years last birthday) 2 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) MARYLAND Datuxent River		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBERT L. ROYCE		14. MOTHER'S MAIDEN NAME SHIRLEY A CAPOROSSI	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 289.0 DUE TO Neimann-Picks Disease		INTERVAL BETWEEN ONSET AND DEATH 2 yrs. 8 mos.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1, 1959, to May 1, 1959, that I last saw the deceased alive on May 1, 1959, and that death occurred at 1:05 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE DR. OVERTON HIMMELWRIGHT		ADDRESS (Street, city or town, state) M.D. 133 Virginia Ave Cumberland, Md. DATE SIGNED 3/28/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-28-59	
22c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		24a. REG'D BY REGISTRAR MAR 30 1959	
		24b. REGISTRAR'S SIGNATURE Arthur J. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WILLIAM STAR DEPARTMENT OF HEALTH - BALTIMORE 19

CERTIFICATE OF DEATH

1915

1915
BALTIMORE
DEPARTMENT OF HEALTH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2551 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

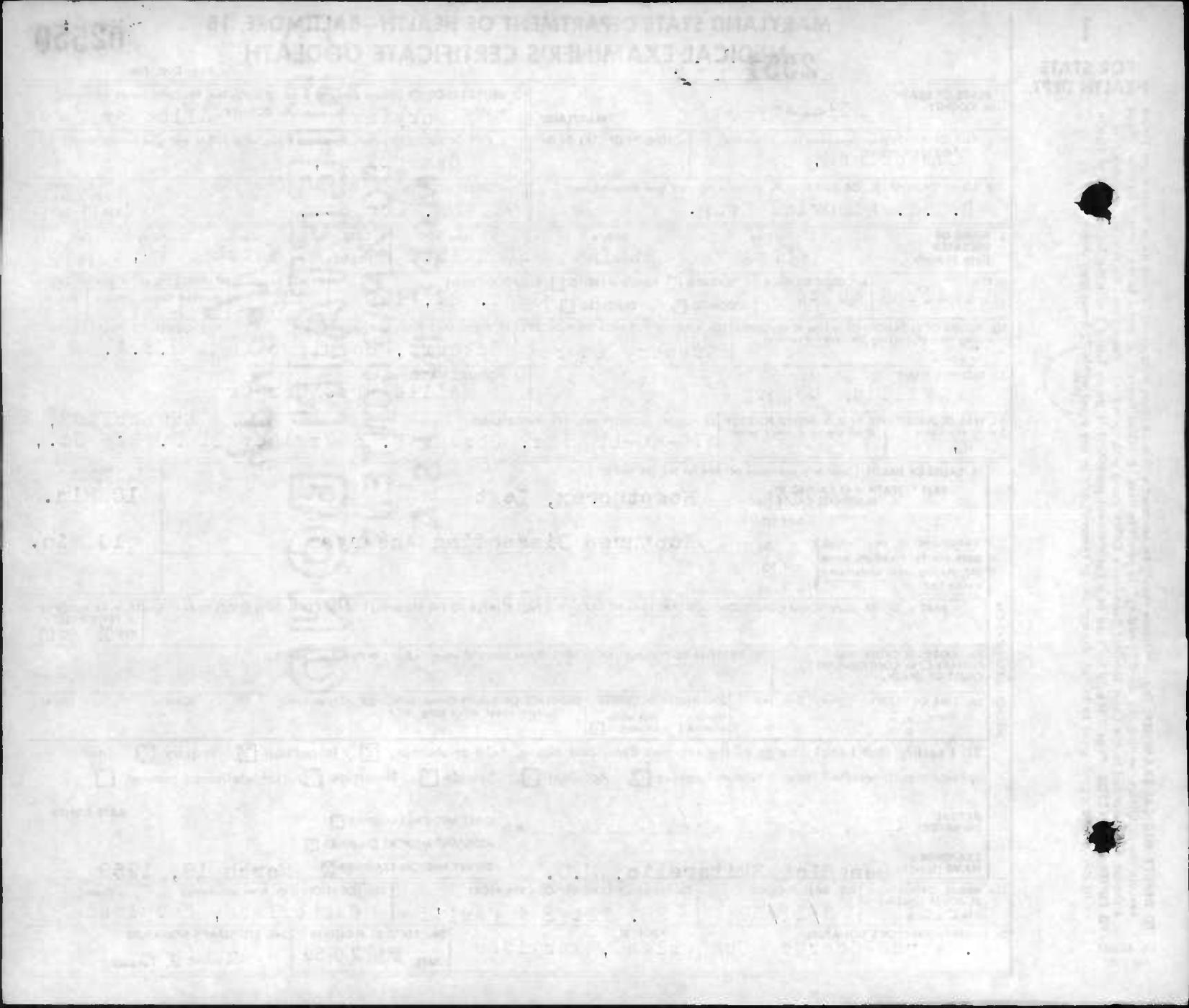
02559

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PHM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any case within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. LENGTH OF STAY IN lb 02		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Memorial Hosp.				d. STREET ADDRESS 21 N. Lee St.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First CLARA	Middle REGINA	Last SCHREIBER	4. DATE OF DEATH Month March Day 18, Year 1959
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 27, 1907	9. AGE (In years last birthday) 51 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Grocery Store		11. BIRTHPLACE (State or foreign country) Eckhart, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME William Condry		14. MOTHER'S MAIDEN NAME Mollie Hershberger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. 578-40-6977		17. INFORMANT Address Mr. Joseph F. Schreiber 21 N. Lee St., Cumberland, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO Hemothorax, Left			
451X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO Ruptured Dissecting Aneurysm			
(b) DUE TO Ruptured Dissecting Aneurysm		DUE TO 10 Min.			
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
19					
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>March 18, 1959</i>	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/21/59		22c. NAME OF CEMETERY OR CREMATORIAL SS. Peter & Paul's	
				22d. LOCATION (City, town, or county) Cumberland, Maryland	
				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Maryland		24a. REC'D BY REGISTRAR DATE MAR 20 '59	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Francis</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2552

CERTIFICATE OF DEATH

Reg. Dist. No. 025611

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 65 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,		d. STREET ADDRESS 515 E. FIRST STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) ELEANOR		First	Middle	Last SHAW	4. DATE OF DEATH MARCH 14 1959	Month MARCH	Day 14	Year 1959
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEBRUARY 14 1880		9. AGE (In years last birthday) 79	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) MARYLAND - KIFER		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME LUKE ROBERTSON				14. MOTHER'S MAIDEN NAME MATHILDA MIDDLETON				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. none		17. INFORMANT		Address		
no						MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Herman</i>								
422.2 DUE TO								
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <i>Myocarditis & Decompensation</i> DUE TO 5 yrs (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>Jan 5</u> , 1959, to <u>Mar 14</u> , 1959, that I last saw the deceased alive on <u>Mar 14</u> , 1959, and that death occurred at <u>12:30 PM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>236 W. Lee Cumberland, Md.</i> DATE SIGNED <i>3/15/59</i>								
ACTUAL SIGNATURE <i>Claye E. Durrett</i> M.D.								
PHYSICIAN'S NAME (Type) CLAYE E. DURRETT								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-17-1959		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Herman Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE James F. Scarpelli, Cumberland, Md. DATE MAR 17 '59 Arthur S. Kraus								

STATE OF MARYLAND - DEPARTMENT OF HEALTH AND HUMAN SERVICES - BALTIMORE 10

CERTIFICATE OF DEATH

NAME OF DECEASED	AGE	SEX	DEATH DATE
EDWARD J. KELLY	60	M	APRIL 21, 1968
ADDRESS OF DECEASED			
101 E. BELMONT AVE.			
BALTIMORE, MD 21212			
NAME OF DOCTOR			
DR. RICHARD L. COOPER			
ADDRESS OF DOCTOR			
101 E. BELMONT AVE.			
BALTIMORE, MD 21212			
TIME OF DEATH			
10:00 PM			
CAUSE OF DEATH			
HEART DISEASE			
METHOD OF DEATH			
NATURAL			
NAME OF FUNERAL DIRECTOR			
J. W. COOPER			
ADDRESS OF FUNERAL DIRECTOR			
101 E. BELMONT AVE.			
BALTIMORE, MD 21212			
TIME OF BURIAL			
10:30 PM			
DATE OF BURIAL			
APRIL 22, 1968			
NAME OF PERSON FILING			
DR. RICHARD L. COOPER			
SIGNATURE			
APRIL 22, 1968			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02561

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		5384		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
Allegany MARYLAND				Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				d. STREET ADDRESS West Main	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First	Middle	4. DATE OF DEATH	Month Day Year
William				Shook	March 27 1959
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday)
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Sept 23, 1884	74 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Morefield, W.Va.	
12. CITIZEN OF WHAT COUNTRY?				U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Address	
George Shook		Virginia See		Lonaconing, Md.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT	
				Mrs. William Shook	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o.) 422.1 DUE TO "Wife" Conditions, if any, which gave rise to immediate cause (o.), stating the under- lying cause lost. (b.) DUE TO Atherosclerosis - CVA (c)				INTERVAL BETWEEN ONSET AND DEATH 1 week years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o.) Glaucoma, Chronic gastritis, Tertiary Syphilis				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1959, to March 27 1959, that I last saw the deceased alive on March 26, 1959, and that death occurred at 5 a.m., from the causes and on the date stated above. ACTUAL SIGNATURE Leslie R. Miles Jr. M.D.				ADDRESS (Street, city or town, state) DATE SIGNED 3.28.59	
PHYSICIAN'S NAME (Type)		LESWIE R. MILES JR		LONA CONING MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/29/59		22c. NAME OF CEMETERY OR CREMATORIAL Memorial Park	
22d. LOCATION (City, town, or county) Frostburg, Md.				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lonaconing, Md.		24a. REC'D BY REGISTRAR DATE APR 1 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CONFIDENTIAL - SECURITY INFORMATION

CONFIDENTIAL - SECURITY INFORMATION

S1 #
FOR STATE
HEALTH DEPT.
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
2553

02562

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P.D.S. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

V.S. AT 5
5M 2/57

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Md.		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Friendsville, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital--D.O.A.		e. STREET ADDRESS		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EUGENE		First EDWARD	Middle SINES	4. DATE OF DEATH March 9 1959	Month Day Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH Oct. 28, 1918	8. DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 40 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sawmill operator		10b. KIND OF BUSINESS OR INDUSTRY Lumber		11. BIRTHPLACE (State or foreign country) Friendsville, Md.	
13. FATHER'S NAME Christ Sines		14. MOTHER'S MAIDEN NAME Orpha Morefield		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 172-16-5100		17. INFORMANT Mrs. Jessie Sines, Friendsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 835X		DUE TO Hemopneumothorax		INTERVAL BETWEEN ONSET AND DEATH 30Min.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO Fracture of 4th-5th ribs, right		30 Min.	
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Tractor upset pinning victim.			
20c. TIME OF INJURY Month, Day, Year Hour 3:15 o.m. Mar. 9 1959		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm 20f. (City or town) (County) (State) Near Corriganville, Alleg. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>March 9, 1959</i>		
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.	DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial	22b. DATE THEREOF 3/12/59	22c. NAME OF CEMETERY OR CREMATORIUM Blooming Rose		22d. LOCATION (City, town, or county) Friendsville, Garrett Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Gen J Neuman</i>		ADDRESS Grantsville, Md.		24a. REC'D BY REGISTRAR MAR 12 '59 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knau</i>	

三

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2554

CERTIFICATE OF DEATH

Reg. Dist. No.

02563

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 4 HRS. 32 MIN. 02		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		
3. NAME OF DECEASED (Type or print) BABY		First MIDDLE GIRL	Last SMITH	
4. DATE OF DEATH MARCH 3 1959		Month MARCH	Day 3	
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH MARCH 3, 1959		9. AGE (In years last birthday) yrs. IF UNDER 1 YEAR Months Days Hours Min 4 32		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME RICHARD E. SMITH		14. MOTHER'S MAIDEN NAME BARBARA A. CLAIRE		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.		
17. INFORMANT WARWICK & MEMORIAL AVENUE MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 759.3 DUE TO Multiple Anomalies INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3 March 1959 to 4 March 1959 that I last saw the deceased alive on 3 March 1959, and that death occurred at 1:24 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE L. Ransom M.D. ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) DR. L. RANSOM M. D. 63 Greene St. Cumberland, Md. DATE SIGNED 4 March 1959				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 4, 1959		22c. NAME OF CEMETERY OR CREMATORIUM XXXX Lewis Cemetery
22d. LOCATION (City, town, or county) Near Oldtown, Md.		(State) Alleg. Co.		
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE MAR 6 '59
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to a burial, cremation, or removal, and in any event within 72 hours after death.

WYOMING STATE BOARD OF HEALTH—BALTIMORE, MD.

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02564

CERTIFICATE OF DEATH

Reg. Dist. No.

2555			
1. PLACE OF DEATH a. COUNTY Allegany Cumberland MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Md.		c. LENGTH OF STAY IN 1b 7 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edward Dillon Smith		First Edward	Middle Dillon
Last Smith		4. DATE OF DEATH Month March	Day Year 27th 19 59
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-1-1885
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Various	11. BIRTHPLACE (State or foreign country) Va.
13. FATHER'S NAME Addison Smith		14. MOTHER'S MAIDEN NAME Parrollix Margaret Parrell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	INFORMANT Pt's Chart, Sacred Heart Hospital
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0		DUE TO extenonlungs heart disease	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) generalized arteriosclerosis		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH 1 year	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2-1-1957 to 2-27-1957 , that I last saw the deceased alive on 3-27-1959 , and that death occurred at 8:30 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Eckhart, Md.	
ACTUAL SIGNATURE L Brings		DATE SIGNED 3-30-57	
PHYSICIAN'S NAME (Type) Dr. Lewis Brings, M.D.		57 Green Street, Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/30/1959	22c. NAME OF CEMETERY OR CREMATORIUM Potter Cemetery
22d. LOCATION (City, town, or county) Eckhart, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight		24a. REC'D. BY REGISTRAR MAR 31 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus
ADDRESS Cumberland, Md.		DATE	

HASS NO 374 1933

1229

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2590

CERTIFICATE OF DEATH

Reg. Dist. No.

02565

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellerslie		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellerslie	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Annie M. Snowden		First	Middle
4. DATE OF DEATH March 5, 1959	Month	Day	Year 19
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH December 4, 1872
8. AGE (In years lost birthday) 86 yrs.	9. IF UNDER 1 YEAR Months 0	10. IF UNDER 24 HRS. Days 0	11. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Bedford Co., Pa.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Nathaniel Smith		14. MOTHER'S MAIDEN NAME Elizabeth Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT None Mrs. Roy Clites, Ellerslie, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Valvular Heart Disease, Chronic DUE TO Approx 15 yrs.		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb. 27, 1958 , to March 5, 1959 , that I last saw the deceased alive on March 4, 1959 , and that death occurred at R M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hyndman, Penna.		DATE SIGNED March 6, 1959	
ACTUAL SIGNATURE John A. Topper		M.D.	
PHYSICIAN'S NAME (Type) John A. Topper, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 7, 1949	22c. NAME OF CEMETERY OR CREMATORIUM Hillcrest Cemetery
22d. LOCATION (City, town, or county) Cumberland, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Harvey H. Engle, Hyndman, Pa.		24a. ADDRESS Arthur S. Turner	24b. REC'D BY REGISTRAR DATE MAR 10 '59

00759
MICHIGAN STATE DEPARTMENT OF HIGHER EDUCATION

CERTIFICATE OF DESIGN

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	1000
---	---	---	---	---	---	---	---	---	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	------

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 on page 3 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2556 CERTIFICATE OF DEATH

Reg. Dist. No. **02566**

1. PLACE OF DEATH a. COUNTY Allegany			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN lb 8 years					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 421 North Waverly Terrace			e. STREET ADDRESS 421 N. Waverly Terrace					
3. NAME OF DECEASED (Type or print) MARY			First ETTA	Middle SPEROW	Lost			
4. DATE OF DEATH March 13		Month Month	Doy Doy	Year Year				
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH June 6, 1888	9. AGE (In years lost birthday) yrs. 70	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Hours 0	IF UNDER 24 HRS. Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Oldtown, Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Thomas Crabtree			14. MOTHER'S MAIDEN NAME Emma Zimmerly			421 N. Waverly Terrace		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Chas. Sperow		Cumberland, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			Mild & later Convalescence of Breast			INTERVAL BETWEEN ONSET AND DEATH Two years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 16 Greene Street	(County) Cumberland	(State) Md.
21. I certify that I attended the deceased from 1955 , to 3-13-59 , that I last saw the deceased alive on 3-10-59 , and that death occurred at 12 PM , from the causes and on the date stated above.								
ACTUAL SIGNATURE James T. Johnson, Jr. M.D.		ADDRESS (Street, city or town, state) 16 Greene Street, Cumberland, Md. DATE SIGNED 3/14/59						
PHYSICIAN'S NAME (Type) James T. Johnson, Jr. M.D.		22c. NAME OF CEMETERY OR CREMATORIAL Davis Mem. Meth. Cem						
22a. BURIAL/CREMATION/REMOVAL (Specify) Burial		22b. DATE THEREOF 3/16/59		22d. LOCATION (City, town, or county) Allegany County, Maryland		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland			ADDRESS			24a. REC'D BY REGISTRAR DATE MAR 19 '59		
						24b. REGISTRAR'S SIGNATURE Arthur S. Trahan		

STATE OF NEW YORK
CERTIFICATE OF DEATH



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2557 CERTIFICATE OF DEATH

02567

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 or 2 could be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 45 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 14 Willison Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Henry Stevenson		First John	Middle Henry
4. DATE OF DEATH March 25 1959	Month March	Day 25	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 9, 1893
9. AGE (In years last birthday) 66 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Operator	11. KIND OF BUSINESS OR INDUSTRY Gasoline	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Samuel Stevenson	14. MOTHER'S MAIDEN NAME Martha Clites		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 217-10-6807	17. INFORMANT Mrs. Etta Wilson, Cumberland, Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Bronchial Asthma 3 years Dept of Aging 10 years			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 212X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 24 , 1959, to March 24 , 1959, that I last saw the deceased alive on March 24 , 1959, and that death occurred at 7:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 202 Virginia Ave. DATE SIGNED 1959			
ACTUAL SIGNATURE E. E. Broadrup		PHYSICIAN'S NAME (Type) Dr. E. E. Broadrup	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-28-59	22c. NAME OF CEMETERY OR CREMATORIUM St. Mary's Cemetery	22d. LOCATION (City, town, or county) Cumberland, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.	ADDRESS	24a. REC'D BY REGISTRAR DATE MAR 30 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Thorne

IT IS OMNITRAC-IT IS A BROADband WIRELESS SYSTEM THAT IS DESIGNED TO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2591

CERTIFICATE OF DEATH

Reg. Dist. No.

02568

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellerslie		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellerslie		d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION									
3. NAME OF DECEASED (Type or print)		First Richard	Middle E. Stuby	Last 	4. DATE OF DEATH March 29, 1959	Month March	Day 29	Year 1959	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED X NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 5, 1897	9. AGE (in years last birthday) 61 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brakeman		10b. KIND OF BUSINESS OR INDUSTRY B&O Railroad		11. BIRTHPLACE (State or foreign country) Fossilville, Pa.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Henry Stuby				14. MOTHER'S MAIDEN NAME Amanda Wolford					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-05-994		17. INFORMANT Mrs. Phoebe Stuby, Ellerslie, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO Congestive heart failure Myocardial Infarction						INTERVAL BETWEEN ONSET AND DEATH 6 mo.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 12-18 , 19 57 , to 3-29 , 19 59 , that I last saw the deceased alive on 3-4 , 19 59 , and that death occurred at 6:30 AM , from the causes and on the date stated above. ACTUAL SIGNATURE William P. James						ADDRESS (Street, city or town, state) 441 N. CENTRE ST.,		DATE SIGNED 3-30-59	
PHYSICIAN'S NAME (Type) WILLIAM P. JAMES, M. D.									
22a. BURIAL, CREMATION, REMOVAL (specify) Burial		22b. DATE THEREOF March 31, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Lybarger Cemetery		22d. LOCATION (City, town, or county) Buffalo Mills, Pa. RD#1		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Harvey W. Feigler,		ADDRESS Hyndman, Pa.		24a. REC'D BY REGISTRAR DATE APR 1 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

新編世界文學名著叢書

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

112569

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town Cumberland	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland Md	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 814 Sylvan Ave.	e. STREET ADDRESS 814 Sylvan Ave.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Anna	First Belle	Middle Stamp	Last March 13 1959
4. DATE OF DEATH Month March	Day 13	Year 1959	
S. SEX F	6. COLOR OR RACE W WIDOWED <input checked="" type="checkbox"/>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 1-24-1878
9. AGE (In years last birthday) 81 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Sylvanus Robey	14. MOTHER'S MAIDEN NAME Mary Doyle		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Mr. Watkins	Address 814 Sylvan Ave.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH Witnessed by Hypocrite with the signature 3 month			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1-2-59, 19, to 3-13-1959, that I last saw the deceased alive on 3-12-1959, and that death occurred at 5 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. 16 Green St.			
ACTUAL SIGNATURE James T. Johnson Jr., M.D.	DATE SIGNED 3-13-59		
PHYSICIAN'S NAME (Type) James T. Johnson Jr., M.D.	Cumberland, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/13/59	22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cem.	22d. LOCATION (City, town, or county) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Laurie Clean Inc.	ADDRESS Cumberland, Md.	24a. REC'D BY REGISTRAR DATE MAR 16 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 could be filed with the registrar, or to burial, cremation, or removal, and in any event within 72 hours after death.

WILLIAM SYAR DEPARTMENT OF HEALTH - ALBANY, NY

CERTIFICATE OF DEATH

Name of deceased		Age at time of death	
Place of residence		Cause of death	
Date of birth		Date of death	
Sex		Color of eyes	
Height		Weight	
Occupation		Religious preference	
Employer		Name of physician	
Address		Signature	
Name and address of hospital where deceased resided		Name and address of hospital where deceased died	
Name and address of funeral home		Name and address of mortician	
Name and address of physician who issued certificate		Name and address of physician who issued certificate	
Signature		Signature	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02570

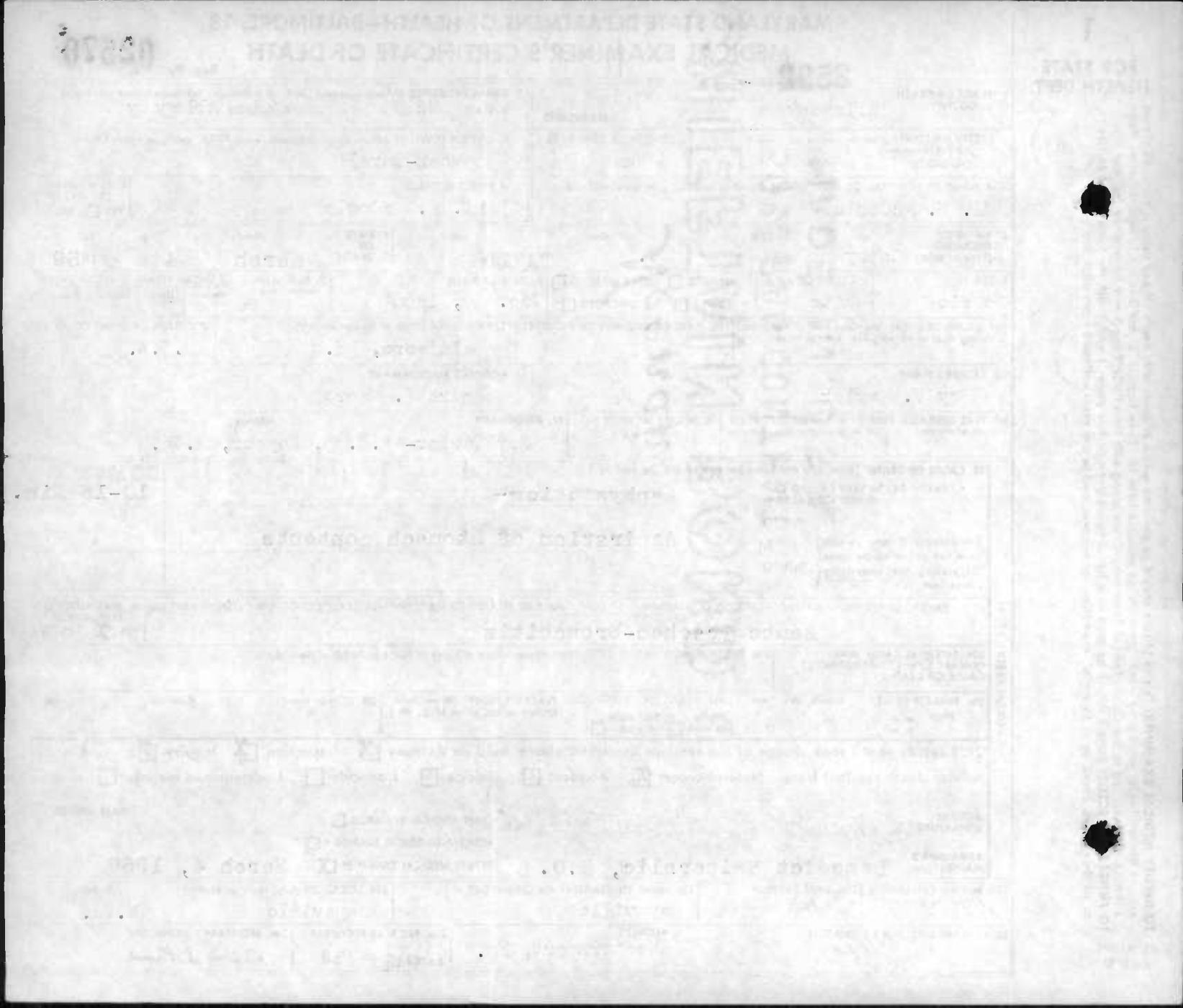
Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 3 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

2592		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)						
a. COUNTY Allegany		b. STATE Md b. COUNTY Allegany						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dawson		c. LENGTH OF STAY IN 1b 6 Wks						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mi. N. McCole		d. STREET ADDRESS 13 Mi. N. McCole						
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
3. NAME OF DECEASED (Type or print) Cathy		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Dec. 30, 1958	9. AGE (In years from birthday) yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Roy F. Taylor		14. MOTHER'S MAIDEN NAME Sandra K. Moore						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address Roy Taylor- R.D. 3, Keyser, W.Va.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Asphyxiation DUE TO 10-15 Min. INTERVAL BETWEEN ONSET AND DEATH								
500X Conditions, if any, which gave rise to immediate cause (a), stoking the underlying cause lost. (b) Aspiration of Stomach contents DUE TO								
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
Acute Tracheo-bronchitis								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
19		19		Maysville		Maysville W.Va.		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Benedict Skitarelic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED March 4, 1959						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/5/59		22c. NAME OF CEMETERY OR CREMATORIAL Maysville		22d. LOCATION (City, town, or county) Maysville (State) W.Va.		
23. FUNERAL DIRECTOR'S SIGNATURE Eloral		ADDRESS Westernport, Md.		24a. REC'D BY REGISTRAR DATE MAR 6 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Krause		
2047151XV5								



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02571

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.		c. LENGTH OF STAY IN lb 5 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA VALE, MARYLAND				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.		d. STREET ADDRESS 15 NORTH LAVALE STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) RUTH		First	Middle	Last	4. DATE OF DEATH MARCH 29 1959	Month	Day	Year
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH AUGUST 2, 1903	9. AGE (In years last birthday) yrs. 55	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
8. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME WILLIAM MCFARLAND			14. MOTHER'S MAIDEN NAME MAUDE MICKEY					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No Address								
16. SOCIAL SECURITY NO. None								
17. INFORMANT MEMORIAL HOSPITAL CUMBERLAND, MARYLAND								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) On Fulmonale INTERVAL BETWEEN ONSET AND DEATH 2 days 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fulmonary Fibrosis and Hilostatic Co. 1ys DUE TO (c) Carcinoma of Lung 7 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 122 S. Central St.		(County) Cumberland		(State) Maryland
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 8:15 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE Ruth E. Silcox ADDRESS (Street, city or town, state) Cumberland, MD. DATE SIGNED APR 3 1959								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/1/59		22c. NAME OF CEMETERY OR CREMATORIUM Rest Lawn Cemetery		22d. LOCATION (City, town, or county) LaVale		(State) Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox				ADDRESS Cumberland Maryland		24a. REC'D BY REGISTRAR DATE APR 3 '59		24b. REGISTRAR'S SIGNATURE Cynthia L. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02572

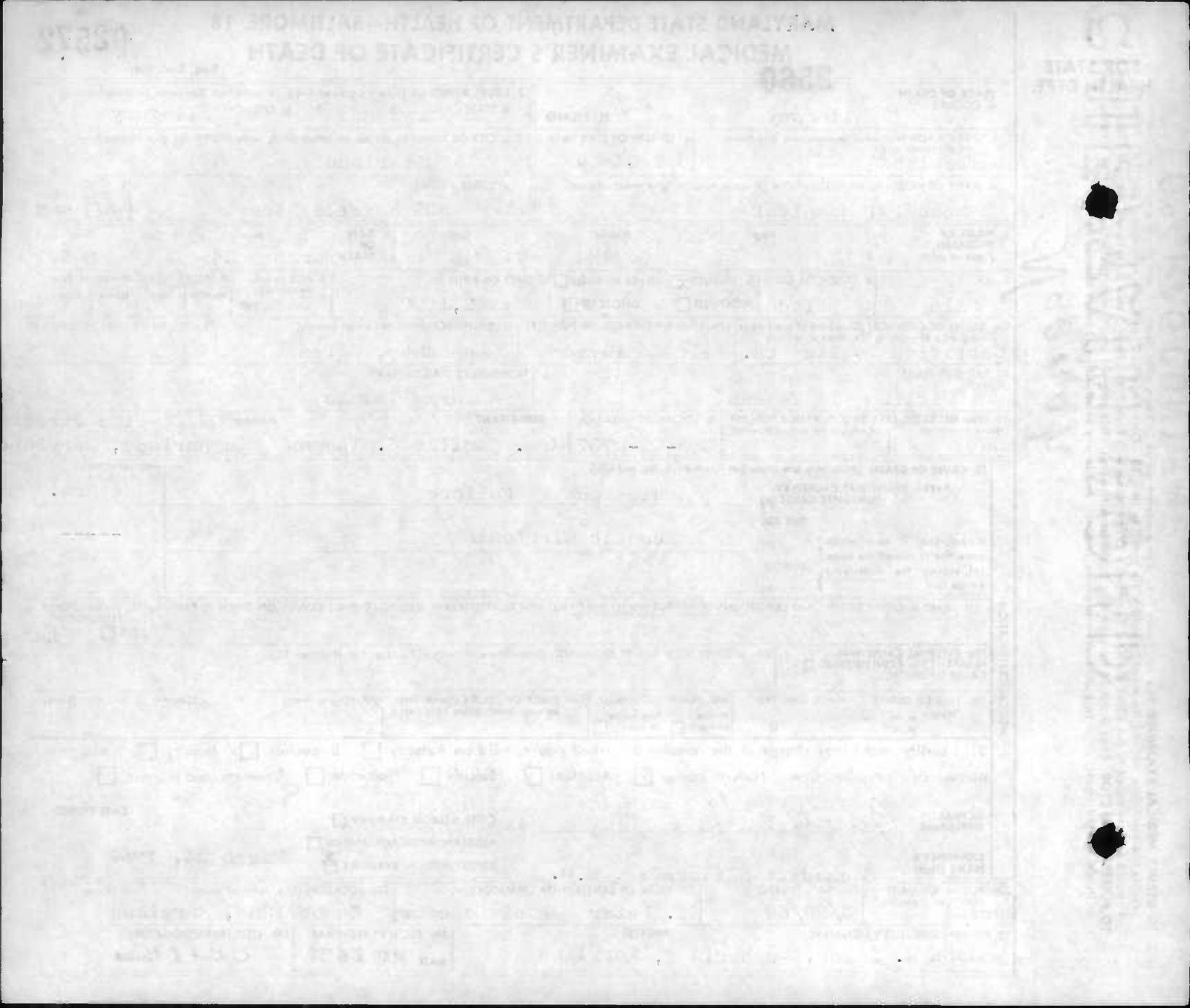
Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File page 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

2560

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 3/23/59	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		e. STREET ADDRESS 909 Fayette Street	
3. NAME OF DECEASED (Type or print) GWILYM		First GOUGH	Middle THOMAS
4. DATE OF DEATH March 24		Last	Month Day Year 19 59
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 22, 1900
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Certified Public Acc.		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	
11. BIRTHPLACE (State or foreign country) Canaskee, Wales		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Thomas		14. MOTHER'S MAIDEN NAME Laura Thomas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 209-09-0737 17. INFORMANT Mrs. Camille S. Thomas	
Address 909 Fayette Street Cumberland, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hepatic Cirrhosis DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 24 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED March 24, 1959
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/26/59	22c. NAME OF CEMETERY OR CREMATORIUM St. Peter & Paul Cemetery	22d. LOCATION (City, town, or county) Cumberland, Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		ADDRESS	24a. REC'D BY REGISTRAR DATE MAR 26 '59
		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	



1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File Pages 1 and 2 with the State Health Dept., or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

**FOR STATE
HEALTH DEPT.**

Item 18 Film 240 4-3-59 ans MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02573

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, nr. Oldtown, Md.		c. LENGTH OF STAY IN 1b 3 mos		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural, nr. Oldtown, Md.				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RT. 4, Box 264, Cumberland, Md.		d. STREET ADDRESS Rt. 4, Box 264, Cumberland, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) THOMAS Eugene WARD		First	Middle	Lost	4. DATE OF DEATH March 23	Month	Doy	Year
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Dec. 20, 1958	9. AGE (In years less birthday) 3 mos	IF UNDER 1 YEAR Moths Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Daniel F. Ward		14. MOTHER'S MAIDEN NAME Rhoda Ritchie						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO. none		17. INFORMANT Daniel F. Ward		Rt. 4, Box 264 Cumberland, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 571.0		ASPHYXIATION				INTERVAL BETWEEN ONSET AND DEATH SUDDEN		
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. (b)		DUE TO ASPIRATION OF STOMACH CONTENTS				II		
DUE TO (c) Gastro-enteritis, Non Specific						2 days		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/25/59		22c. NAME OF CEMETERY OR CREMATORIUM Sunset Memorial Park		22d. LOCATION (City, town, or county) Cumberland, Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE MAR 26 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

n2574

2561

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 2 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND							
d. NAME OF HOSPITAL OR INSTITUTION MEMORIAL HOSPITAL WARWICK & MEMORIAL AVENUES				d. STREET ADDRESS 4 GRAND AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) ELIZABETH		First V.	Middle WELCH	Lost	4. DATE OF DEATH MARCH 8, 1959.	Month MARCH	Day 8	Year 1959			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH SEPTEMBER 1,	9. AGE (In years last birthday) yrs. 42	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Variety Store		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME RUSSELL STEWART		14. MOTHER'S MAIDEN NAME BESSIE P. MILLER		Address							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-05-7947		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 340.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour a.m. p. m.		Month Mar.	Day 5	Year 1959	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 256 W. Ave Cumberland	20f. (City or town) Cumberland	(County) M.D.	(State) MD.		
21. I certify that I attended the deceased from Mar. 5, 1959 , to Mar. 8, 1959 , that I last saw the deceased alive on Mar. 8, 1959 , and that death occurred at 2:42 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Clay F. Durrett										ADDRESS (Street, city or town, state) 256 W. Ave Cumberland	DATE SIGNED 3/8/59
PHYSICIAN'S NAME (Type) DR. CLAY F. DURRETT											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 11, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Hillcrest Burial Pk.		22d. LOCATION (City, town, or county) Cumberland, Md.		(State) MD.			
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		ADDRESS		24a. REC'D BY REGISTRAR MAR 13 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 sheet 2 detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MANUFACTURED TO HIGH-SPECIFICATION

CERTIFICATE OF DATA

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2562

CERTIFICATE OF DEATH

02575

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE PENNSYLVANIA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 10 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL AND WARWICK AVENUES		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKWOOD	
3. NAME OF DECEASED (Type or print) ALBERT		First J	Middle WEYAND
4. DATE OF DEATH MARCH 3 19 59	Month MARCH	Day 3	Year 1959
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH NOVEMBER 17 19
9. AGE (In years (at birthday) yrs. 79	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		Address CUMBERLAND, MD.	
13. FATHER'S NAME ALBERT WEYAND			
14. MOTHER'S MAIDEN NAME ELIZABETH HOWARD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	
	175-16-9472A	MEMORIAL HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Cirrhosis chronic Carlos Tavarin 3 yrs			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Benzos Promethazine Hypnotic by mouth retention			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 21 Feb 1959 to 3 Mar 1959 , that I last saw the deceased alive on 2 Mar 1959 , and that death occurred at 4:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. 122 So Center St, Cumberland, Md, 21401			
ACTUAL SIGNATURE James G. Stegmaier		DATE SIGNED	
PHYSICIAN'S NAME (Type) JAMES G. STEGMAIER			
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF March 6, 1959	22c. NAME OF CEMETERY OR CREMATORIUM Rockwood Cemetery
22d. LOCATION (City, town, or county) Rockwood Pa		(State) Pa	
23. FUNERAL DIRECTOR'S SIGNATURE William J. Hood		24a. REC'D BY REGISTRAR DATE MAR 11 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event, within 72 hours after death.

WISCONSIN STATE DEPARTMENT OF HEALTH - DIVISION TO

CERTIFICATE OF DEATH

REGD.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

n2576

Reg. Dist. No.

2563

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA		b. COUNTY MINERAL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 23 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIDGELEY		d. STREET ADDRESS 117 MAIN STREET			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First GERTRUDE	Middle MAE	Last WHEELER	4. DATE OF DEATH MARCH 26 1959	Month MARCH	Day 26	Year 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DECEMBER 23, 1881	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) OHIO GREENBRIER, CO.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME URIAH SAVILLE				14. MOTHER'S MAIDEN NAME ROSE WEIGLE					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT WARWICK & MEMORIAL AVENUE MEMORIAL HOSPITAL - CUMBERLAND, MD.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH 20 years!			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.8		A _d eno carcinoma of colon							
DUE TO									
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b)									
DUE TO									
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 2 - 30 , 19 59 , to 3 - 26 , 19 59 , that I last saw the deceased alive on 3 - 26 , 19 59 , and that death occurred at 11:10PM , from the causes and on the date stated above. Rever W. Ballin ACTUAL SIGNATURE				ADDRESS (Street, city or town, state) 62 Greene St.		DATE SIGNED 2-28-59			
PHYSICIAN'S NAME (Type) DR. RALPH BALLIN				Cumberland, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 29, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Hillcrest Burial Park, Cumberland, Md.		22d. LOCATION (City, town, or county) Cumberland, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE CHARLES L. GEORGE, CUMBERLAND, MD.		ADDRESS		24a. REC'D BY REGISTRAR MAR 30 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Krause			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 could be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1238
FBI BROWNSBURG HIGHWAY PATROL STATE GUARDIAN

THIS IS TO STAY WITH YOU

231

SEARCHED

AT BROWNSBURG

CITY POLICE

SEARCHED INDEXED SERIALIZED FILED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02577

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Logs 1 and 2 with the State Board of Health, TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

2564

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 21 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		d. STREET ADDRESS 182 Thomas Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) THOMAS WARD		First W	Middle H	Last THOMAS	4. DATE OF DEATH March 8
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 10, 1937	9. AGE (in years last birthday) 21	IF UNDER 1 YEAR Months 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY High School		11. BIRTHPLACE (State or foreign country) Cumberland, Md.	
13. FATHER'S NAME Carl R. White		14. MOTHER'S MAIDEN NAME Laura N. Troxell		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Mr. Carl R. White, Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (b) Coronary Atherosclerosis DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Benedict Skitarelic'</i>	EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	DATE SIGNED March 8 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-11-1959	22c. NAME OF CEMETERY OR CREMATORIUM Hillcrest Burial Park	22d. LOCATION (City, town, or county) Cumberland, Md.	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		ADDRESS	24a. REC'D BY REGISTRAR MAR 10 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02578

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
 To FUNERAL DIRECTOR: Page 3 should be used as a Burial-transit Permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

2565		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)								
1. PLACE OF DEATH a. COUNTY Allegany		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b Memorial Hospital		d. STATE Maryland b. COUNTY Allegany				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		f. STREET ADDRESS 108 W.Third St.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) FRANCES		First Emily	Middle WICKARD	Last WICKARD	4. DATE OF DEATH March 3 1959	Month March	Day 3	Year 1959		
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 7, 1903	9. AGE (In years from birthday) 55 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dishwasher	11. KIND OF BUSINESS OR INDUSTRY Restaurant	12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Samuel T. Mears			14. MOTHER'S MAIDEN NAME Martha E. Reese							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. 213-24-7378		17. INFORMANT Sylvester W. Wickard		Address Cumberland 108 W. 3rd St., Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) Intracerebral Hemorrhage (c) DUE TO Hypertension and Sclerosis						INTERVAL BETWEEN ONSET AND DEATH 15 days				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED March 3, 1959				
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		22b. DATE THEREOF 3/5/59		22c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park		22d. LOCATION (City, town, or county) Cumberland, Maryland		(State)		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24a. REC'D BY REGISTRAR MAR 6 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>						
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Md.								
VS. AT 5ME 5M 2/57										

YUGOSLAVIA

YUGOSLAVIA

STATE BO

YUGOSLAVIA - INVESTIGATION ANALYSIS

YUGOSLAVIA

INVESTIGATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02579

2566

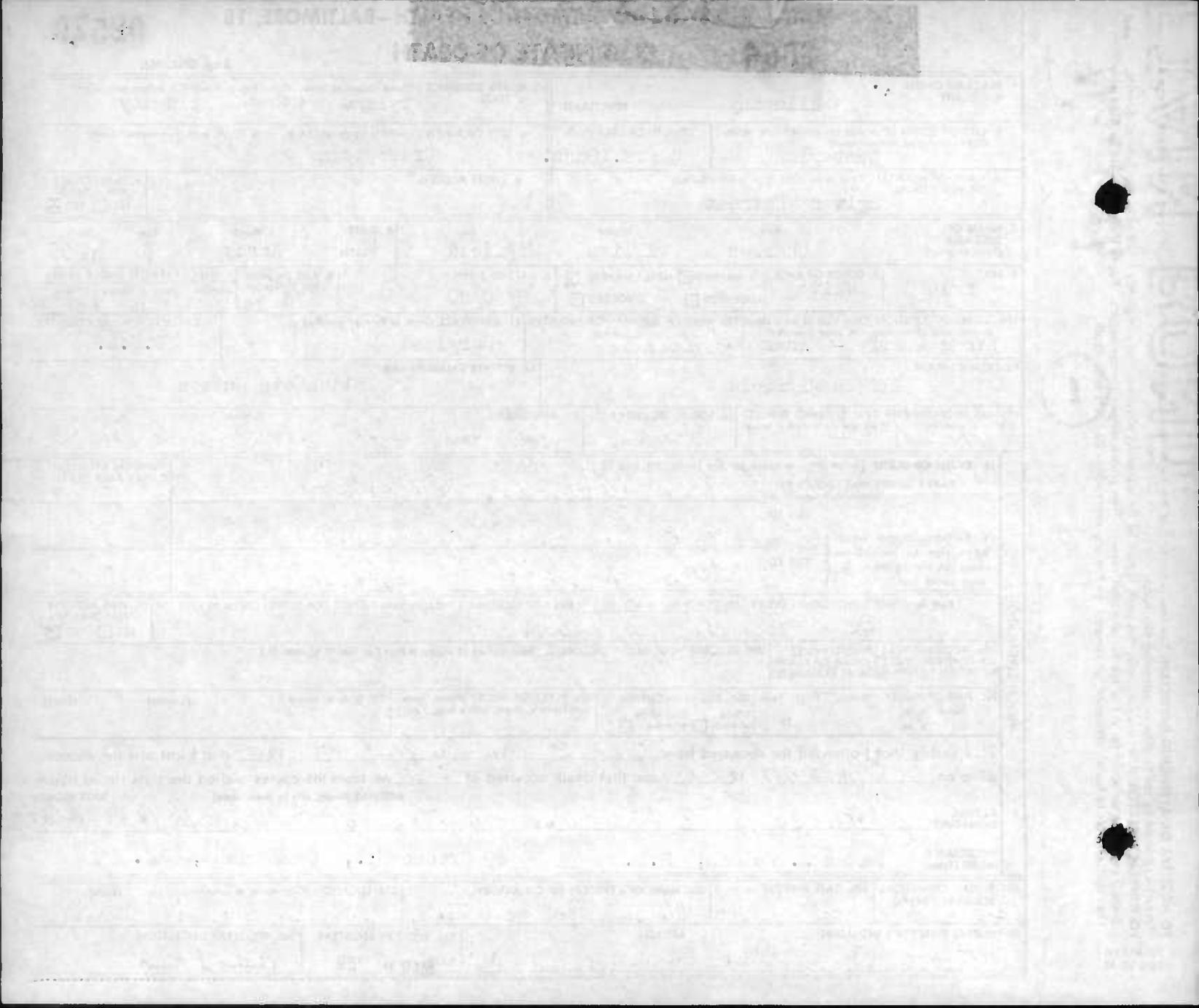
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 4 yrs. 10mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sylvan Retreat		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Charles	Middle William	Last Wigfield
4. DATE OF DEATH Month March	Day 3	Year 19 59	
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/30/80
9. AGE (In years lost birthday) 78 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stone Quarry - Miner	11. KIND OF BUSINESS OR INDUSTRY Industrial	12. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Elijah Wigfield	14. MOTHER'S MAIDEN NAME Elizabeth Watson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Tel. no. or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Sylvan Retreat Cumberland	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) 450 DUE TO (c) 592 Chronic Nephritis		INTERVAL BETWEEN ONSET AND DEATH ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 304 Severe psychosis.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month Day, Year 19	20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 3, 1954</u> , to <u>Mar. 3, 1959</u> , that I last saw the deceased alive on <u>Feb 28th, 1958</u> , and that death occurred at <u>6 a. M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)	ADDRESS (Street, city or town, state) <u>James E. McLean, M.D.</u> 49 Greene St., Cumberland, Md. DATE SIGNED <u>3/3/59</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Mar. 5, 1959</u>	22c. NAME OF CEMETERY OR CREMATORIUM <u>Allegany Co. Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Cumberland</u> <u>md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sons Stein, Inc. Cumberland, Md.</u>	ADDRESS <u></u>	24a. REC'D BY REGISTRAR DATE <u>MAR 9 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 could be filed with the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **02580**

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 24 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Anna		First Wilfong	Middle Last March 26 19 59
4. DATE OF DEATH March 26 19 59	Month Day Year	Month Day Year	Month Day Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/9/96
9. AGE (In years lost birthday) 62 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) W.Va.
12. CITIZEN OF WHAT COUNTRY U.S.A.	13. FATHER'S NAME George Martin		
14. MOTHER'S MAIDEN NAME Anna Albright		Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	17. INFORMANT Chart
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 420.1 DUE TO Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 6m.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO CV Disease		INTERVAL BETWEEN ONSET AND DEATH Link.	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Recent operations ① Bunions + hammertoes ② Umbilical hernia + adhesions			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1 Mar 19 59 , to 26 Mar 19 59 , that I last saw the deceased alive on 26 Mar 19 59 , and that death occurred at 10 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Carter Brinsfield		ADDRESS (Street, city or town, state) 232 Baltimore Ave, Cumberland, MD 21501	
PHYSICIAN'S NAME (Type) Dr. C. Brinsfield		DATE SIGNED 3/15/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3/28/59	22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill	22d. LOCATION (City, town, or county) (State) Thomas W. VA.
23. FUNERAL DIRECTOR'S SIGNATURE John A. Daniels, Thomas, W. VA.		24a. REC'D BY REGISTRAR DMAR 30 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Harrel

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02581

2568

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

*Patent was under care of Dr. Leg / Bradock Road, Cumberland, Md.
 In this final illness, I saw patient only in consultation
 Please do not let him know I told about this form*

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 39 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS 1018 Shades Lane		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1018 Shades Lane				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First Robert	Middle Charles	Last Williams	4. DATE OF DEATH March 11 1959	Month March	Day 11	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH June 3, 1919	9. AGE (In years last birthday) 39	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto repair		10b. KIND OF BUSINESS OR INDUSTRY Streets Body shop		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John W. Williams		14. MOTHER'S MAIDEN NAME Elizabeth Clites Gray						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. II 217-10-7845		17. INFORMANT Mrs. Robert Williams		Address Cumberland, Md		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myelogenous Leukemia						INTERVAL BETWEEN ONSET AND DEATH 3 months		
204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.	Month 0	Day 19	Year 1950	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 59 Greene St	(County) Cumberland	(State) Maryland
21. I certify that I attended the deceased from _____, 1950, to 25 Feb., 1959, that I last saw the deceased alive on _____, 1959, and that death occurred at 11:00 PM, from the causes and on the date stated above. Please see margin to left ADDRESS (Street, city or town, state) 59 Greene St DATE SIGNED 3/13/59								
ACTUAL SIGNATURE <i>Weisman</i>		M.D.						
PHYSICIAN'S NAME (Type) S. G. WEISMAN MD				Cumberland, Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/14/59	22c. NAME OF CEMETERY OR CREMATORIAL Zion Memorial Park		22d. LOCATION (City, town, or county) Cumberland, Maryland		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox		ADDRESS Cumberland Maryland		24a. REC'D BY REGISTRAR MAP 17 '59	24b. REGISTRAR'S SIGNATURE <i>Ruth E. Silcox</i>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2585

CERTIFICATE OF DEATH

Reg. Dist. No.

82582

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md		b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		c. LENGTH OF STAY IN lb 62 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 43 Westernport					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 109 McKinley		d. STREET ADDRESS Westernport-R.D.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Violet Virginia		First	Middle	Last	4. DATE OF DEATH Mar. 24	Month	Day	Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 22, 1896		9. AGE (In years lost birthday) 62 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Joseph E. Youst			14. MOTHER'S MAIDEN NAME Mary E. Thomas						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Geraldine E. Youst-Westernport, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Arterio-sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None									
INTERVAL BETWEEN ONSET AND DEATH 6 Days 5 Years									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None							
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) M.D.		(County) Westernport	(State) Md.
21. I certify that I attended the deceased from March 18, 1959, to Mar. 24, 1959, that I last saw the deceased alive on Mar. 18, 1959, and that death occurred at 3:25 A.M. from the causes and on the date stated above.									
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Paul R. Wilson		ADDRESS (Street, city or town, state) M.D. 11 Ashfield St. Piedmont, W.L. 3-24-59							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/27, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Philos		22d. LOCATION (City, town, or county) Westernport			
23. FUNERAL DIRECTOR'S SIGNATURE E. Berl		ADDRESS Westernport, Md.		24a. REC'D BY REGISTRAR DATE MAR 26 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 to be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02583

2565 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 4 HRS. 34 MINS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL AND WARWICK AVENUES		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First BABY	Middle GIRL	Last WOLFE
4. DATE OF DEATH	Month MARCH	Day 10,	Year 19 59
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 10, 1959
9. AGE (In years from birth) yrs. Months 02	10. IF UNDER 1 YEAR Months 2	11. IF UNDER 24 HRS. Days 34	12. IF UNDER 24 HRS. Hours 4 hrs 34 mins
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME CHARLES E WOLFE	14. MOTHER'S MAIDEN NAME CAROLE J SCHOENADEL	Address CUMBERLAND MARYLAND	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 776X	16. SOCIAL SECURITY NO.	17. INFORMANT MEMORIAL HOSPITAL	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. Diseasmatly (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 4-5 months Feb 4 hrs 34 mins
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3/10 , 19 57 , to 3/10 , 19 57 , that I last saw the deceased alive on 3/6 , 19 59 , and that death occurred at 2:06 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE B. M. Schneider M.D. ADDRESS (Street, city or town, state) 43 Everett Cumberland, Md. DATE SIGNED 3-11-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/11/59	22c. NAME OF CEMETERY OR CREMATORIUM Pleasant Grove Cem.	22d. LOCATION (City, town, or county) Cumberland, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE H. Lee Silcox	ADDRESS Cumberland, Md.	24a. REC'D BY REGISTRAR DATE MAR 13 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Death

Date of death

Cause of death

Time of death

Place of death

Name of physician

Name of hospital

Name of coroner

Name of funeral director

Name of embalmer

Name of mortician

Name of cemetery

Name of funeral home

Name of funeral director

Name of embalmer

Name of mortician

Name of cemetery

Name of funeral home

Name of funeral director

Name of embalmer

Name of mortician

Name of cemetery

Name of funeral home

Name of funeral director

Name of embalmer

Name of mortician

Name of cemetery

Name of funeral home

Name of funeral director

Name of embalmer

Name of mortician

Name of cemetery

Name of funeral home

Name of funeral director

Name of embalmer

Name of mortician